S. HRG. 102–673, PT. 2

ECONOMIC GROWTH AND THE PRESIDENT'S BUDGET PROPOSALS

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

SECOND SESSION

ON

S. 267, S. 693, S. 1398, S. 1932, and S. 2220

FEBRUARY 18 AND 19, 1992

(Part 2 of 2)

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ECONOMIC GROWTH AND THE PRESIDENT'S BUDGET PROPOSALS

TUESDAY, FEBRUARY 18, 1992

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 2:20 p.m., in room SD–215, Dirksen Senate Office Building, Hon. Lloyd Bentsen (chairman of the committee) presiding.

Also present: Senators Moynihan, Baucus, Bradley, Mitchell, Riegle, Rockefeller, Daschle, Roth, Danforth, Chafee, Durenberger, Symms, Grassley, and Hatch.

[The press release announcing the hearing follows:]

[Press Release No. H–6, Feb. 3, 1992]

SENATOR BENTSEN CALLS HEARINGS ON ECONOMIC GROWTH, PRESIDENT'S BUDGET; FINANCE CHAIRMAN CITES NEED FOR SWIFT ACTION

WASHINGTON, DC—Senator Lloyd Bentsen, Chairman of the Senate Finance Committee, Monday announced a series of hearings on economic growth and the President's budget proposals.

Bentsen (D., Texas) said the hearings will be at 10 a.m. on Wednesday and Thursday, February 12 and 13 and Tuesday and Wednesday, February 18 and 19 in Room SD–215 of the Dirksen Senate Office Building.

"The Finance Committee held hearings last November and December to examine the state of our economy and help us plan action for turning our economy around. The President submitted most of his budget proposals last week and now we need to take a close look at them," Bentsen said.

"Our economy is in a rut. Growth in our Gross Domestic Product was a tiny 0.3 percent in the fourth quarter and consumer confidence, as measured by the Conference Board, is at its lowest level since May 1980. We're having to extend emergency unemployment compensation benefits yet again because unemployment continues to rise. Jobs and the economic health of millions of Americans hang in the balance.

"These hearings will provide a wide range of views on how best to invigorate our economy. We'll examine the President's proposals for tax increases and cuts, for health care and how his budget would affect our economy," Bentsen said.

"I intend to move as quickly as possible to pass legislation to help American families get the help they need. These hearings on growth proposals, including the President's budget, will help move that process forward," Bentsen said.

Bentsen said Administration witnesses will testify on the President's tax proposals on February 12; the February 13 hearing will include testimony from economists and private sector representatives regarding how tax proposals offered by the President and Congress will affect the economy in the short and long term; the February 18 hearing will have Administration and private sector witnesses discussing the President's health proposals; Members of Congress and additional witnesses will testify on February 19.

OPENING STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS, CHAIRMAN SENATE FINANCE COMMITTEE

The CHAIRMAN. This hearing will come to order. I scheduled this hearing to consider the President's budget on health, income security, and social service programs that come within the jurisdiction of this committee.

This year the President sent to Congress a budget which calls for an unexpectedly generous increase in health care spending for discretionary programs, such as the Maternal and Child Health Block, and relative to last year's budget, it is a substantial increase.

Remarkably small cuts in the major entitlement programs, such as Medicare, Medicaid, and Child Welfare Services have been requested relative to previous years. In fact, the budget's release was overshadowed by the President's announcement of his Comprehensive Health Care Reform proposal.

The two, I think, Mr. Secretary, really intertwine, because the President included a 38-page chapter in his proposal which discusses options for deep cuts in Medicare and Medicaid programs to offset the estimated $100 billion, 5-year cost of the tax credits and the deductions in his health care plan.

After more than a decade of attempts to make large cuts in the annual Medicare and Medicaid budgets, the administration seems to have seen the light, or maybe it anticipated the heat, and took steps to avoid an unpleasant confrontation in an election year.

But, regardless of the motivation, I want to commend President Bush and Secretary Sullivan for a more reasonable set of recommendations than I have seen in previous years.

With 60 percent of hospitals experiencing losses from treating elderly or disabled patients, deep cuts in Medicare programs are simply not defensible. Especially if they are not part of a comprehensive strategy to contain the overall growth in health care costs.

I am anxious to hear the Secretary's statement. We are pleased to have him here. In particular, I am interested in the administration's recommendations for further reducing infant mortality in rural areas and in the inner cities.

I am also looking forward to learning about plans for improving immunization rates amongst children, especially in light of the President's recommendation that Congress agreed to cap overall spending in the Medicaid program.

We also have with us today Larry Mathis, of Houston, representing the nation's 5,700 hospitals; two spokespersons for the health care professionals who administer anesthesia; experts who will comment on the administration's proposals to curb Medicare reimbursement for laboratory services and durable medical equipment; an AARP representative to speak on behalf of consumers of Medicare and Medicaid services; and a witness who will speak on behalf of the Children's Defense Fund about the President's recommendations for changes in the Medicaid program.

Now, as members of the committee develop their bills in this session, some may wish to use administration budget recommendations to offset spending initiatives.

Accordingly, today's testimony will be helpful to us as we evaluate the President's recommendations on his program. And I will be

looking forward to hearing from each of our distinguished witnesses.

I believe Senator Chafee was the first to arrive.

Senator Chafee.

OPENING STATEMENT OF HON. JOHN H. CHAFEE, A U.S. SENATOR FROM RHODE ISLAND

Senator CHAFEE. Thank you very much, Mr. Chairman. We are heading into a difficult period because a lot of decisions have to be made, not only in health care, but tax policy.

And I seek all the guidance I can obtain, particularly when we hear the conflicting statements from the candidates in the New Hampshire primary.

I see that the House has enacted a bill that provides for a $200 tax credit for single persons and $400 a couple.

And yet, the leading Democratic candidate in the New Hampshire primary has said, "That is generationally irresponsible; it is robbing children to pay the parents. It is a Santa Claus give-away, and I am not Santa Claus."

So, Mr. Chairman, I look forward to the hearings we will be having. And if anyone can enlighten me on how we can resolve our differences, it would be extremely helpful.

Mr. Chairman, I have a statement, but I would just like, if I might, to comment on a couple of points. My comments amplify the remarks you were marking, namely that I think we ought to all congratulate the President for coming forward with a program to improve our health care system.

Now, that does not mean we have to agree with every part of the program, but the important thing is that it brings the administration into the debate.

Now, most members of this committee have sponsored some form of health care reform, whether it is one introduced by the Democratic leadership, or by you, Mr. Chairman, or by the proposal that I introduced, with 22 other Republican Senators.

And we all have the same objectives: to slow the increasing cost of our health care system and to provide critically needed health care for about 36 million Americans who are uninsured, and, thus, in most instances, do not have access to good medical care.

The amazing thing, Mr. Chairman, is the similarity between these health care reform proposals. Yes, there are differences, but there are many similarities, and I will just highlight some of them: insurance market reform; the establishment of small group purchasing organizations; 100 percent deductibility of health insurance premiums for the self-employed; increased funding for community health centers; reduction in administrative costs; State experimentation, encouraging managed care; and, in some of the proposals, medical liability reform.

Now, I do not think we have to stick to only those seven or eight areas of reform. I think if we could get agreement on those areas—and we ought to be able to—we could expand to other areas of reform. And this will not be easy. I think it is going to require that everyone set aside his or her ideological differences.

But I commend the President for submitting his plan, and look forward to discussing reform proposals, as well as changes in the Medicare and Medicaid programs mentioned by today's witnesses.

And I especially want to thank Dr. Sullivan, because he has had a leading role in advancing health care reform legislation. I am delighted you are here, Doctor, and I want to thank you, Mr. Chairman.

[The prepared statement statement of Senator Chafee appears in the appendix.]

The CHAIRMAN. Thank you. I see in the order of arrival that Senator Hatch is next.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH

Senator HATCH. Thank you, Mr. Chairman. Welcome, Dr. Sullivan. We are happy to welcome you here as the Secretary of Health and Human Services to provide us information on the President's budget and Health Care Reform package.

In his State of the Union address and in his speeches in Cleveland and San Francisco 2 weeks ago, President Bush identified health care reform as a top national priority.

Families all across our country are suffering from the ills besetting our health care system: lack of access for many; escalating costs for all.

In my home State of Utah, many women, particularly in rural areas, are finding it difficult to obtain obstetrical services because of the reluctance of family practitioners to provide obstetrical care. And that is going on all over the country.

I believe that the President's proposal correctly places its emphasis on market-based reform approaches to improve our health care system. And while we all agree that we need to improve our system, we must recognize that the American system of health care is not without certain fundamental strengths.

For instance, our system provides high quality care for the vast majority of our citizens. We lead the world in biomedical research and give hope to all those whose family members suffer from disease.

Today we will learn more about the details of the administration's proposals, and there are many elements in this plan that would go far in improving access to and controlling the cost of health care.

As I see it, there are really five basic reforms: Medicare reform; Medicaid reform; anti-trust reform; medical liability reform; and insurance reform. I think all of those are important if we are going to understand how we might do it, and an approach towards coordinated care.

That is, getting people to be able to make good sense arrangements with health care providers to provide their health care needs.

So, I think the administration has clearly put forth a major proposal on the table, and I think this committee should give it very careful consideration.

And, Mr. Chairman, I note that there are several steps in the President's plan that are very similar to the provisions in your bill that will be the subject of this committee's hearing on Thursday.

The President's plan is also similar in many key aspects to the bill developed by the Republican Health Care Task Force.

The principle behind the President's plan—take strong, but measured, steps to improve our current market-based system. It is a wise course that many approve of, and will benefit the great majority, if not all, of our citizens.

And, as we deliberate over this issue, we would do well to recall the observation made by Moliere. He said, "Men more often die of their remedies than of their maladies."

I believe that this is the time to reform and improve our health care system, not re-create the system, as some would have us do, by making unwarranted and untested changes.

And I believe that with the President's leadership on this issue we have the opportunity to preserve the best features of our current system. We can improve access to care and control cost escalation.

Now, I am going to listen today with great interest to the details of the President's program, and I will listen with particular interest to the critical issue of financing these changes.

As I plowed my way through the 94-page white paper, it was not always clear to me precisely how much these changes will cost and who will pay for them, so I hope that Secretary Sullivan can enlighten us on these questions and other important issues as we go through our hearings today.

Now, there is much at stake in our efforts to fix our Nation's ailing health care system. Families all across this Nation are counting on us to succeed so that they can be confident of having financial security and access to affordable, quality health care. I hope that we can achieve this goal.

I see lots of problems. Back in 1960, 6 percent of our Gross National Product was spent on health care; today, 12.2 percent or more. And by the year 2001, some are estimating between 15 and 19 percent of our GNP will be spent on health care.

And if we do not change the system by the year 2020, we may be a little over 31 percent of our Gross National Product. If that happens, we will not have any money to spend on any other social programs. So, it is very important that we provide leadership at this time and do what has to be done to reform our system.

And, Dr. Sullivan, I want to give you a lot of credit for doing the leading in this administration in trying to bring about the effective changes that we need in this country that will help to resolve these critical, very, very complex problems for all of society, and I just want to personally thank you for it.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much. Senator Durenberger, any comments?

OPENING STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Perhaps briefly, Mr. Chairman. First, thank you for the opportunity to be here by holding this hearing, and welcome the Secretary and all of the other witnesses.

I congratulate Larry Mathis for taking over the AHA; a thankless task, but only a Houstonian or Minnesotan could do it well, I am sure.

Just by way of alerting the Secretary of the kind of question I would like to ask him in a budget context, I think one of the things that we have sort of missed out on since last Thursday in the President's presentation is just exactly how this might impact on Medicaid and the opportunities for the States in this country to finally come to grips with the problems of accessing low-income Minnesotans, and Texans, and everyone else to adequate medical care.

And I would hope that either in your statement or at some point you would be able to make it clear to all of us that opportunity that is presented by the President's capping of Medicaid, and the voucher approach, and the challenge to the States to come up with some creative benefits.

In other words, it seems to me the challenge is to the States to get as much coverage as they possibly can with that fairly substantial Federal dollar.

I know we are going to hear a lot of criticism about the fact you cannot buy this for $12.50; you cannot buy that for $37.50. That entirely misses the point. That whole line of argument entirely misses the point.

The point here is that there are much better ways to help low-income Americans access the system and I trust that you may be able to help us understand the direction that the President is pointing us in that regard.

The last thing I would say, Mr. Chairman, is we have been doing this for many, many years on this committee, holding a hearing about this service being cut, and that service being cut.

And I have just come to the conclusion lately that we get in America exactly what we pay for: a whole bunch of services. We get 9,000 doctor services; we get 468 hospital services. And if you really want to know what is wrong with the cost of health care in America, it is because we are not buying the right things.

And we sit here every year saying "we paying too much or too little for this surgery, or that surgery; or this office visit, or that office visit," and we are totally missing the point.

And I hope that perhaps the administration and others during the course of these hearings can give us some insight into a better direction we, as the biggest third-party payors in America, could go in rewarding more efficient practice of medicine.

The CHAIRMAN. Thank you very much, Senator.

Senator Baucus.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you, Mr. Chairman. Dr. Sullivan, I would like to report on my recess in Montana. Once a month I tell people at home I do an honest day's worth.

That is, I work at some job. I report to work at a saw mill, or a mine, or wait tables at 8:00 o'clock in the morning. I bring my sack lunch. I am one of the employees; one of the guys and gals, and I punch out at 5:00 or 6:00, or whatever time everybody quits.

This last week I worked a day in a hospital. I spent half of the day as a physical therapist. I spent a good part of it, until the noon hour, talking with doctors and nurses.

I spent another part of a day working in a doctor's office in a nearby medical clinic filing records, trying to help the doctor and his nurse bring patients from the reception room and take some records.

And, I must tell you, I am not a very good nurse or doctor, because I could not take blood pressure very well—I had a heck of a time trying to find the pulse.

But what I am really saying is this: I strongly urge you, the administration, and all of us to follow what I think the American people want, and that is, in 1992, to avoid gimmickry, "quick-fixes" and address the fundamentals.

The American people now know that the time is here for us to not indulge in band-aids, not indulge in trying to piece a faulty system together, but to come up with some results that make sense.

Now, I recently talked to 50 doctors in Missoula, MT. We talked about this issue about an hour and a half during the noon hour. At the end of it, I asked a question. I said, how many of you think that we should, in Montana, try to come up with a demonstration project that makes sense in our State to address health care reform? And 90 percent of the hands went up.

I then asked a question, and I found the results very interesting. I said, "how many of you think that we should go down the road of a single payor system, not knowing exactly where it is going to go, but how many think we should go down that road?" Eighty percent of the doctors in the room raised their hand affirmatively that we should try it.

So, the point is, I am surprised at the degree to which doctors are fed up with the system, and they are willing to pursue change. Some are willing to give up, perhaps, a little bit of income for more stability so they can practice medicine more and not put up with all the paper work, et cetera.

Obviously, the American people want more access. They want more coverage, really, not just band-aid coverage. They also know that the system is starting to collapse; it is starting to implode because it is too top heavy.

So, essentially what I am saying to you is I know it is hard, it is a Presidential campaign year, we may not get much accomplished as a consequence.

But I urge you, I urge the President, I urge all of us to—it sounds trite but it is true—to put the politics aside and the gimmickry aside, and let us come up with something that is really substantial. Because the best politics in the long run is no politics; it is do what the American people want, be honest about it.

And there is an opportunity here for us to truly work together, not just take potshots at each other and ridicule each other's ideas.

And I hope that we, in Montana, can come up with a pilot demonstration project. You all know that in California, Minnesota,

many States are attempting to do just that. And maybe some States can come up with an idea, and I hope they do. I hope we, in Montana, can.

But it is also my hope that after awhile some of the best plans are put together as we, in fact, do have a national plan so that every American, regardless of age, sex, income, has the peace of mind of knowing that he or she can get high quality health care without having to worry about the bills.

It is incredible to me how we have this opportunity now to address it. The American people want it, and, yet, to some degree, a lot of these proposals going around just barely work on the fringes, they are barely on the edges.

And I think the problem is if we pass something just on the edge, that we are going to congratulate ourselves and we will not have addressed the problem, and we will have precluded an opportunity to address what is really going on here. So, I just urge us to solve this thing. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Roth, do you have any comments?

OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE

Senator ROTH. Thank you, Mr. Chairman. It is, indeed, a pleasure to welcome you, Secretary Sullivan. I do have a prepared statement. I would ask that it be included as it is read.

[The prepared statement of Senator Roth appears in the appendix.]

The CHAIRMAN. That will be done.

Senator ROTH. Because I do have to leave early, I would ask, Mr. Chairman, that we be allowed to submit written questions.

The CHAIRMAN. That will be fine. That will be accepted.

[The questions appear in the appendix.]

The CHAIRMAN. Senator Symms, did you have any comments?

OPENING STATEMENT OF HON. STEVE SYMMS, A U.S. SENATOR FROM IDAHO

Senator SYMMS. Mr. Chairman, I will be as brief as possible. I, too, would ask unanimous consent to insert my entire statement into the record as though read.

The CHAIRMAN. That will be done.

Senator SYMMS. I would just like to make brief comments, and, Mr. Secretary, welcome you here. Thank you, Mr. Chairman, for having this hearing.

But I think there is a fundamental issue that does need to be aired here with respect to these health proposals, and I think the President's proposal seems to me like it is well thought out, comprehensive, and it definitely heads in the right direction.

I have studied some of the proposals that our colleagues on the other side of the aisle have offered, and one that has received a lot of attention is pay-or-play, which appears to me like it is more or less legalized racketeering; that you either force people to play by the government's rules, or tax them into submission. The other one, of course, is nothing other than the Canadian plan, which is social-

ized medicine. I do not think the American people want either one of those.

And so, I hope that we can take the President's approach, Mr. Chairman, and go for market-based reform which would build on the strengths of this system, which are the best technology, the best-trained doctors, and the best health care in the world. The problem is we need to make it affordable for more people.

And his proposal will provide access to health insurance for all the poor families by means of a refundable tax credit. It also includes medical liability reform; insurance market reform; and encourages the growth of coordinated care. The other proposals are all based on government control.

So, I think what we have here is a classic confrontation between having government control, or control by the forces of individual choice which has served this Nation so well in the past. I think the President is going in the right direction.

Now, there are a couple of things that confuse me by some of the criticism I hear. When the President proposes a tax credit for the poor to buy health insurance, I would think that our friends on the Democrat side of the aisle would be enthusiastically in support. But that does not seem to be the case.

Now, I think—and I am just summarizing here—that the President's position does not go quite far enough. I have introduced a bill, Mr. Secretary, along with my colleague from Idaho—and I am interested in Senator Baucus' comments about some State trial areas of this, but what we would do is allow everyone to have a tax credit when they buy health insurance.

In other words, refundable for low-income individuals. We would allow everyone a tax-exempt savings accounts to save for their out-of-pocket expenses so they could carry higher deductible insurance, therefore, lowering the costs of their premiums, if they so chose.

And we recognize that it must be paid for, so we said, we give every American a Chevrolet tax credit for a health plan, and those that choose Cadillac plans provided by their employers receive the money the employer contributes, and that is, be viewed as taxable income. That pays for the whole program. This would be the logical conclusion of what the President is talking about in his proposal.

This bill is not something that I wrote alone. I got a lot of help from the Heritage Foundation, and from the National Center for Policy Analysis in Dallas.

And I hope that the administration will seriously look at this, and I hope that our colleagues on the committee will as well, because what we are really talking about here, Mr. Chairman, is a classic confrontation.

And I will say it again: do you want the government to run this whole program and have a socialized medicine scheme where we end up with rationing and poorer health care than we have enjoyed, or do we want a system where all Americans can buy insurance and allow the market system to work?

That is basically what the fundamental issue is, and I think that you and the administration deserve commendation. You did not go as far as I would like to see you go, but you certainly made a step in the right direction.

And I think that if we are going to salvage a good health care system in the United States which we have always enjoyed, that is the direction we should go. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Realizing the time constraints, the Majority Leader, I see, is here, and I will call on him now for any comments he would like to make.

OPENING STATEMENT OF HON. GEORGE J. MITCHELL, A U.S. SENATOR FROM MAINE

Senator MITCHELL. Mr. Chairman, I thank you very much for holding this hearing. I thank the Secretary for being here. I regret that I will not be able to stay for much of the hearing, but I wanted to come to express my interest in the subject.

I have a prepared statement, Mr. Chairman, will I ask be made part of the record.

The CHAIRMAN. That will be done.

Senator MITCHELL. I would like, if I might, to respectfully respond briefly to the comments of our colleague from Idaho, who suggested that the choice confronting us was the President's plan, or socialized medicine.

I submit to my colleagues and to the American people that is exactly the argument that Republicans made when Medicare was proposed. It was called Socialism, a Red plot, and every other pejorative term that could be suggested.

It took 10 years to pass Medicare. But now I have not been able to find a single Republican elected official who favors the repeal of Medicare. And I invite any Senator here who favors the repeal of Medicare to now so state. Is that socialized medicine?

Mr. Secretary, I will ask you, when you get to the time for questions, whether the administration regards Medicare as socialized medicine and favors the repeal of Medicare. It is a government-run program.

I happen to think that, despite its flaws and failures, it is one of the success stories in America's quest for social justice and good care and opportunity for all. And I think it is wrong to suggest that the only choices are between the President's plan and socialized medicine.

The American people now see through those red herrings. They know that is not the issue. They know that is just a pejorative phrase used to frighten people, just as that phrase and others was used during the debate over Medicare.

Legislation which many of us introduced builds on the current system. It retains all of the private rights of choice that now exist. It encourages employers to provide health insurance. It is the single most viable alternative to the administration's plan, and it, by no fair description, can be called socialized medicine.

So, I hope that we can get into a discussion and a debate on the merits of the various plans without resort to pejorative labels of that type. I think it will be constructive. I think it will be healthy, and I think we can come up with what I hope will be a good and meaningful plan.

And I conclude by repeating, I would like to know whether any Senator here favors the repeal of Medicare because it is a government-run program.

Senator SYMMS. Well, Senator, if you are asking me the question——

Senator MITCHELL. Yes, I am.

Senator SYMMS. There are two Democrat bills before us. One, I called legalized extortion, that is pay-or-play. The other one is the Kerrey—I do not know whether the Senator from Maine cosponsors it or not—Canadian socialized medicine plan.

There are two Democrat plans before us, and the President's plan. I do not think repealing Medicare is the issue. But I think that the Senator would have to say that the day Medicare passed, that is the day that medical costs started escalating in this country, because we began a program in which the individuals who benefit cannot pay for it so we charged everyone else. That is the problem.

And until we address that problem, my bill would allow for every American to be able to afford a health insurance plan; give everybody a tax credit, refundable for the poor.

And that would go a long way toward restoring market choices which the Senator says he wants. And that is all I am saying. Medicare, I do not think, is the issue here.

Senator MITCHELL. This obviously is not the time for the debate on the various merits. I will simply say that I do not believe that the legislation that the Senator has sponsored will accomplish what he says it will. I respect his right to think the same of the legislation which I have authored.

But I think it is notable that not one person, including the Senator from Idaho, would now repeal Medicare, even though—not these individual Senators here, but their predecessors—pronounced that as Socialism and a Red plot at the time it was adopted.

Senator SYMMS. Senator, if I could make one other comment. We have all kinds of doctors in Idaho today that refuse Medicare patients, so the program denies patients the opportunity to get the treatment. So, I do not think it is a perfect program, by a long shot.

Senator MITCHELL. I believe I said in my opening comments that it has many flaws.

Senator HATCH. Mr. Chairman.

Senator MITCHELL. But I repeat my statement, and I challenged all of the news organizations in America—the New York Times, ABC, NBC, the Washington Post—to see if they could find for me one Republican elected official who would come out and favor the repeal of Medicare. I am not greedy. I am not asking for two; just one. They have not found one yet.

Senator HATCH. Mr. Chairman.

The CHAIRMAN. Gentlemen. Gentlemen.

Senator HATCH. Mr. Chairman, since he asked——

The CHAIRMAN. I would like to get through the rest of statements.

Senator HATCH. But since he asked all of us, I would like to make just one comment.

The CHAIRMAN. No, wait a minute. I would like to allocate the time and stay to it.

Senator HATCH. That will be fine. But I do not think the comments are very accurate.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Mr. Chairman, I would like to find out what Dr. Sullivan thinks about Medicare. [Laughter.]

We welcome you, sir.

The CHAIRMAN. Mr. Secretary, we are delighted to have you. Would you proceed? And I would say to my colleagues, you will have a chance to answer when your time comes.

STATEMENT OF HON. LOUIS W. SULLIVAN, M.D., SECRETARY OF HEALTH AND HUMAN RESOURCES, WASHINGTON, DC

Secretary SULLIVAN. Thank you very much, Mr. Chairman, and members of the committee. I very much appreciate this opportunity to appear before you to discuss our budget proposals for the next fiscal year.

I also want to express to you, Mr. Chairman, my appreciation for accommodating my schedule so that I could appear here today.

Health and Human Service issues are of paramount interest to the members of this committee and to the American people.

I am of the strong opinion that all the programs we forge as government officials should be "family friendly."

As we all recognize, the family is the first and most effective health and human services organization. I firmly believe that both the President's budget proposal and his health plan that he unveiled on February 6th are family friendly.

The budget addresses the real needs of the American family, particularly our children, and our health plan provides families the peace of mind that they will have health care coverage when they need it.

Each of the President's health care proposals makes a contribution toward affordability of insurance, slower growth in costs, improved access, continuity of care, and the security of health insurance.

I realize that together we will be continuing the dialogue on health care reform in the weeks and the months ahead. But I want to underscore my belief about the President's proposal.

Presentation of the President's proposal this month has transformed the nation's debate about health care, and the stakes in this debate are high.

Will we increasingly turn to government, subjecting our health care sector to the whims and the vacillations of budgets and Federal bureaucrats? Or, will we maintain our mixed public/private health system, drawing on the best strengths of the private market?

Now, I put my faith in a system labeled "Made in the U.S.A." The President's plan, which provides efficient and affordable care, which wrings out excess and waste and controls Federal growth; this plan is a practical one, based on what works, and it contains innovative approaches, such as those found in the Bentsen/ Durenberger/ Chafee small market reform plans.

The President's plan will give American families the kind of health care they want and deserve and will put an end to the worry that keeps them up at night.

Now, before taking your questions, I would like to briefly review a few of the highlights of our budget proposal. Our budget has a

particular emphasis on the well-being of children, especially children at risk of long-term dependency and poor health.

The 1993 budget for HHS includes some $76 billion for health and welfare programs benefitting children, with an increase of almost 10 percent from the current fiscal year.

This includes discretionary programs, such as Head Start, and it includes entitlement programs, such as Aid to Families with Dependent Children, Medicaid, and the Social Security program.

For 1993 alone, we propose an increase of $600 million for Head Start; the largest increase ever made in the history of this program. And our budget also includes an increase of $4.4 billion for child health programs.

Now, for Head Start, funding will more than double in the 4 years since 1989, and enrollment will increase by 73 percent. The funding level proposed for 1993 will mean that every eligible 4-year-old child whose parents wants it will be able to have a Head Start experience of at least 1 year.

For Child and Maternal Health, Medicaid funding will increase by $4.2 billion, to more than twice the level of 4 years ago.

And public health services for children will increase by $200 million in fiscal year 1993. That includes $79 million more for the Healthy Start program, targeted to high-risk areas, to cut infant mortality in half.

We are continuing to make improvements in the Family Support Act, a landmark law which is, in large part, the product of the work of this committee. All 50 States now have JOBS programs in place to provide training and job opportunities to AFDC recipients to assist in achieving self-sufficiency. In addition, States have been aggressive in implementing the Child Support Enforcement provisions of the statute.

Our budget calls for two important modifications in the Aid to Families with Dependent Children program. One proposal would give States the option to raise the asset limit for AFDC recipients to $10,000, from the current level of $1,000. These savings could be used to improve the education, training, or employability of a family member, or to purchase a home.

Another proposal would allow States to promote entrepreneurial activities among AFDC recipients by developing self-employment plans and excluding all income and resources related to such plans.

These proposals will provide additional approaches to encourage low-income Americans to move toward self-sufficiency. That is the essence of the American dream, and it should be within the grasp of all of our citizens.

To help States provide our children with quality services, we are proposing to change the financing of State child welfare activities to allow States greater flexibility in meeting the needs of all children in crisis.

The new Comprehensive Child Welfare Services capped entitlement program would be funded at $1.3 billion in fiscal year 1993, increasing to $2.2 billion by fiscal year 1997.

We in government have a role to play in helping our children and our families, but there is simply no replacement for personal responsibility.

Fathers abandoning their children, violence on the streets of our cities, and poor health habits among our citizens cannot be combated by merely adding more to a government authorization or appropriation. These problems can only be truly tackled by individuals taking responsibility for their actions. I called it building a "culture of character."

To draw from the wisdom of that trenchant social philosopher, Barbara Bush, "What happens in your house is more important than what happens in the White House."

We know, for instance, that there is a distinct connection between children in poverty and single-parent families. Children missing a parent are more vulnerable; they are five times more likely to be poor, and twice as likely to drop out of school than children who live with both parents.

In any given year, 9 out of 10 children from two-parent families avoid poverty, but one out of two children living in female-headed households are poor.

In fact, the increase in the proportion of mother-only families accounted for about half of the overall increase in child poverty from 1979 through 1987.

Clearly, government has a role in addressing this problem through such programs as Child Support Enforcement. But, without parents—fathers, in particular—assuming parental responsibility for their sons and their daughters, too many children will continue to suffer both economically and emotionally.

We must, as a nation, recapture the spirit of family, the spirit that nurtures, protects, and strengthens our children. We have no more important task than that.

In closing, I look forward to working with the members of this committee in forging a budget and reforming the health care system in a way that puts families first.

That, I believe, is our charge from the American people. Thank you, and I welcome your questions and your comments.

[The prepared statement of Secretary Sullivan appears in the appendix.]

The CHAIRMAN. Well, Mr. Secretary, you heard me in the beginning comment about how pleased I was on recommended funding for the Maternal and Child Health program, and, of course, for Head Start. I feel strongly about seeing that we have children born with sound minds and bodies, and that we provide prenatal and neonatal health care for them.

And I am delighted to hear the conclusion of your statement. I know how concerned you are with the number of babies that are being born in this country with serious handicaps, a lot of times because of drug addiction on the part of the mother.

Now, I have introduced a bill that has also been introduced by Senator Moynihan, and Senator Mitchell, and 19 others, to prevent this kind of a tragedy by giving more pregnant women and mothers with children access to comprehensive prevention and treatment programs.

It also helps the States with much-needed preventative services so that we can have fewer children who experience the pain of being separated from their parents and placed in foster care.

I know how many times you have been in hospital rooms and looked at boarder babies. What an incredible tragedy and moral problem: babies that are going to spend a year or more there, because no one will take them for a lifetime.

Now, what I would like to know, with these objectives we share, Mr. Secretary, are you ready to work with me and the members of this committee on S. 4, which address some of these problems?

Secretary SULLIVAN. Mr. Chairman, we certainly do, as you have indicated, share your goals.

I am not sure how many hospitals over the last 3 years I have visited, I can clearly remember seeing those babies, for example, an infant in the Henry Ford Hospital in Detroit, who had been there almost 18 months—with a bill of almost $2 million, and there was very little prospect of ever leaving the hospital and becoming self-sufficient.

So, indeed, we look forward to working with you, Mr. Chairman, to find better answers for addressing this problem.

As you know, the President has increased our budget for treatment and prevention and research for drug abuse problems. And I have been particularly concerned about the difficulties that have been related to me by pregnant women around the country who need to into drug treatment programs.

The CHAIRMAN. Absolutely. Let me get to another one, because I have set a time limitation on myself here, and on all of us.

One of the things the President suggested is that some of the health care reform proposals he has offered be financed by cuts in Medicaid and by cuts in Medicare. As I understand it, he proposed paying each State a per capita amount for each Medicaid beneficiary.

I am told it would be increased from 5 to 8 percent annually, which is several points below the rate of increase in health care costs. We are talking about a 12 to 13 percent increase.

Now, as far as I know, there is no evidence that Medicaid programs have been inefficient—they have approximately 4 percent in administrative costs—or that they have been overly generous in their payments; quite the contrary.

The Prospective Payment Review Commission reported last year that the reimbursement by Medicaid for hospital services averaged 78 percent of costs. That is compared to 93 percent of costs for Medicare. And, due to low reimbursement to physicians, there are getting more and more doctors refusing to take Medicaid patients.

Now, if you capped the rate of growth in Medicaid, is it not going to exacerbate that problem? Can you explain to me the rationale for cutting the Medicaid program to finance coverage for the uninsured?

In other words, why should we finance insurance for one vulnerable group of citizens by taking away money from programs that help other vulnerable groups of citizens—that is, the low-income pregnant women, children, disabled, and elderly covered by Medicaid?

There was talk here a moment ago about rationing health care. Is that not what happens? Explain to me that contradiction.

Secretary SULLIVAN. Thank you, Mr. Chairman. Let me first say that, indeed, there will be, under the President's plan, no cut in absolute dollars in the Medicaid program, and no cut——

The CHAIRMAN. No. But you are talking about a 5 to eight percent increase as the costs go up 12 and 13 percent. That is sure cuts.

Secretary SULLIVAN. Right. As you know, Mr. Chairman, we have experienced an average increase in our Medicaid program exceeding 20 percent per year, and this past year the increase was 30 percent. I think we would all agree that that rate of increase is not sustainable.

The CHAIRMAN. But we have also expanded it substantially insofar as the number of people being covered.

Secretary SULLIVAN. Right. But, clearly, the dollars are increasing. What the President's proposal will do is work to spend those dollars more efficiently, because there are ways the system operates now so that those dollars are not spent efficiently.

And, of course, you cannot look at just any one component of the President's plan—you would have to look at it in its entirety. Let me give you an example of what I mean.

In the Medicaid program, our Inspector General has a study which has shown that two-thirds of the Medicaid recipients using emergency rooms do not have an emergency. That is inappropriate use.

But those emergency rooms cost the system three to five times what it would cost for that individual to get care in a doctor's office or in a clinic.

And I maintain that that care in a doctor's office or clinic is actually better for that individual, because in an emergency room, those health care professionals are taking care of people with gun shot wounds——

The CHAIRMAN. But you know why they are there, because they are broke and because they do not have insurance. And at the last minute when the kid is too sick, they rush to the emergency room. I was at Texas Children's the other day, helping dedicate it. And they said they had $43 million worth of uncompensated health care last year.

Secretary SULLIVAN. Mr. Chairman, the President's plan would address both of those, because, for the first time, those individuals would have access to insurance under the President's plan, through the insurance credit.

And, therefore, they would no longer have the need to delay care and come into the emergency room late, but rather they would come in early where the costs would be less and the outcomes would be better.

The uncompensated care problem, also, that Texas Children's Hospital and other hospitals face would also be addressed because there would be a financing mechanism for those individuals.

I think this is a good example of why the President's proposal has to be looked at in its entirety. If you look at simply one portion without seeing how it works comprehensively, it could be misunderstood.

But, clearly, this would address the situation you cited, and I think you would agree that it is much better, if you have influenza,

to come into a doctor's office or into a community clinic and get care there. The care you get will be better; also it will be more comprehensive.

So, it is through changes in the system that these savings would be addressed. And the dollars that we are investing now, which, as you know, are already far in excess of any other nation, would be utilized more effectively.

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman. Dr. Sullivan, I am very pleased that the President's budget contains increased funding for community health centers and for the migrant health centers.

My question to you is, do you envision this money being used to start new health centers, or will existing health centers be allowed to expand? It is my understanding that there have been no new community health centers started in the last several years.

My questions relate to an area that you and the Chairman were discussing, namely, the use of emergency rooms rather than primary care centers. It seems to me, if patients had access to more and larger health centers, they would go there. But the trouble is, there are not enough community health centers, so patients go to the emergency room instead.

And I think this scenario is true even for a relatively modest injury; an injury that is not of an emergency nature but one which a patient wants a doctor to treat, so, they wanted the doctor to treat it, they go to the emergency room because there is no other place to go.

Secretary SULLIVAN. Senator Chafee, the budget does propose $90 million more for community centers, which would take our budget total up to, I think, some $640 million for community and migrant health centers. We envision the addition of 126 new community centers under this program.

Senator CHAFEE. New ones?

Secretary SULLIVAN. New centers. Or, also, expansion of some of the existing community centers, so that we could have a total of some 1,700 sites that community health centers would be operating to increase access to health care. So, indeed, we envision both new centers, as well as expansion of existing centers.

Senator CHAFEE. Well, that is good. I think you will find in this committee there is near unanimity and approval of the use of community and migrant health centers.

Secretary SULLIVAN. Senator Chafee, if I could just add onto that, if I might. Let me give you an example of what I mean, which also gets back to my discussion with Senator Bentsen.

In the State of Missouri, our Inspector General found the average doctor's office visit cost $50. If you go to an emergency room, the average cost is $240.

So, there you have almost a five-fold difference in what the system pays. And when that care is not appropriate for an emergency room, it is cluttering up the emergency rooms as well. So, it is really that kind of saving which we think is quite substantial.

Senator CHAFEE. All right. Now, the next question is, when we enacted the Omnibus Budget Reconciliation Act in 1990, we increased the reimbursement for federally-qualified health centers—the community health centers, really, in most instances.

This was a reimbursement for Medicare; we provided that the community health centers would receive a little more for the Medicare services than a private doctor would receive for the same procedure.

And the rationale for this difference in payment was that a private doctor could even out his charges to some degree between his other patients, whereas that is not possible in a community health center.

So, we got that increased reimbursement included in the Omnibus Budget Reconciliation Act of 1990. But the trouble is, the implementing regulations have not yet been issued. When will the regulations be published? Do you know?

Secretary SULLIVAN. I will get a response back to you for the record on that, Mr. Chafee.

Senator CHAFEE. Well, I do not want to suggest that this is a total emergency but this was a provision of the 1990 Budget Reconciliation Act; 3 years ago.

Secretary SULLIVAN. I would agree with the implication of your question, Mr. Chafee. We would like to get those out as rapidly as possible, and I will have to really find out just where they are, and I would be happy to get a response back to you.

Senator CHAFEE. All right. Fine. I would appreciate that because it is important for increased reimbursement for the community health centers to be implemented.

The CHAIRMAN. You mean not in the emergency room.

Senator CHAFEE. That is right. Now, Dr. Sullivan, one quick question. As you heard me say, if you were listening, in connection with my opening statement, I believe there is a lot of commonality to the health care reform proposals that are out there: the Chairman's; mine; the Majority Leader's; yours.

My question is this, do you think we could sit down and try to proceed with those common points and get them enacted this year? Let me just briefly highlight the areas of similarity—some of these areas are big items like medical liability reform—any time you tangle with medical liability reform, you are getting into a dog fight.

As I see it, the areas of similarity are encouraging managed care; reducing administrative costs—something you are working on already; State experimentation; increased funding to community health centers—you have that, as you mentioned before; 100-percent deductibility of health insurance premiums for self-employed, or some increased percentage over the existing 25 percent; and insurance market reform.

Would you be willing, as the administration's spokesman on this, to sit down with us and hopefully the Democrats as well, and try to come up with some progress this year?

Secretary SULLIVAN. Senator Chafee, I would be very anxious to do just that. Our objective is to provide services for the American people.

We have a system, as I think Senator Symms mentioned, that really is a first-rate system, but it is a system with problems. We want to address the problems.

And, of course, we could tick off all of the strengths of the system, which I think are often forgotten or ignored as we talk about

the deficiencies. But the people who do not have health insurance, that is a problem, and we are anxious to address that.

The medical liability problem, that is a problem. A third of our rural counties around the country do not have obstetrical services because of that. People who live in those counties, they have a severe problem.

So, yes, we are anxious to sit down with you and with the Chairman and with anyone else, because we are ready to roll up our sleeves and try to solve this. That is what I would like to do.

Senator CHAFEE. Well, Mr. Chairman, I just want to say, in conclusion, I think there are prospects of doing something this year. Now I know many shake their heads and say, no, no.

And I do not think it is going to be the great major overhaul has some anticipate, but we certainly could make an awful lot of progress with these areas of commonality that I just listed, and I just wish we would do that. Thank you.

The CHAIRMAN. Senator Hatch.

Senator HATCH. Thank you, Mr. Chairman. Mr. Secretary, I share the President's concern that affordable access to health care be improved for all Americans.

Now, how does the President's plan affect the access to care for the following populations: the uninsured, the unemployed, the reemployed, and the middle-class families where the breadwinner is enrolled in a small group insurance plan that has seen large increases in premiums over the years?

Secretary SULLIVAN. Senator Hatch, the President's plan, I am pleased to say, has a positive economic benefit for more than 90 million Americans. For the poor and the unemployed, we have available a tax credit that would make up to $3,750 available for families for the purchase of insurance.

And that is a sum, by the way, which our actuaries, in consultation with actuaries in the private sector, have determined would purchase a basic health insurance plan. I make that point, because there are some out there who either have not examined our plan or are not aware of the details and who are claiming that that is not the case; that it would not.

We are not talking about business as usual; we are not talking about the "Cadillac" plan or the plan that is loaded down with every conceivable thing. And we know that there are some 1,000 mandates out there on various State plans, including such things as hair transplants or herbal wraps as mandates.

And for someone who wants an herbal wrap, that might be very important. But it is my position that that is not crucial to the health of our citizens, and, therefore, where it impedes access by driving up the costs, we need to get rid of it.

So, the plan would provide, first of all, the insurance voucher for the poor. For those families with incomes up to $80,000, they would be able to deduct on their taxes the cost of their health insurance programs.

But beyond those 90 million people who would be directly affected, we all would be affected. Because the rest of the people with insurance, through the cost shifting that is occurring in our system now, are paying in their premiums for the uninsured.

So, indeed, everyone would benefit from the President's plan, including more than 90 million directly, either through the voucher or through the tax deduction.

Senator HATCH. Mr. Secretary, what is meant by the use of the term "basic health insurance" in the white paper? In other words, I assume that that means that not everyone could get a liver transplant, for instance.

But what can you tell us about where the line is going to be drawn, and what can you tell us about what would be included in the basic health package that the actuaries used to come up with the $1,250 per individual, $2,500 for a couple, and $3,750 for families?

Secretary SULLIVAN. Senator Hatch, what we propose to do is to have flexibility for the States in defining the package, in consultation with my office. But we deliberately want to let the States participate in this process, which is why we have not defined the specifics of the package.

The responsibility of each State Insurance Commissioner would be to see that a minimum of two basic health plans are available to the citizens in his or her State.

My office will have the responsibility of consultation with those commissioners to see that fundamental issues in a basic plan are addressed. But this is really for ultimate discussion with the States.

Senator HATCH. All right. Just having said that, what are the effects of the President's plan on the States' authority to regulate health insurance, or insurance companies, in general?

Secretary SULLIVAN. There will continue to be a major role of the States for such regulation. However, we do envision that if the States are unwilling, or unable to provide such a plan, that there will be a Federal mechanism to encourage and ultimately to see that that is done.

But we believe that the leadership is best handled by the States, because the needs of one State, for example, the State of Vermont, may be very different from another, say, Alaska. So, we do not believe that a one-size-fits-all approach is the best approach, but rather want to leave that for discussion with the States.

Senator HATCH. Thank you. I see my time is up, Mr. Chairman.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Yes. Thank you very much. This is a flip chart showing Medicaid growth. It shows a very large growth over the last 2 or 3 years. One percent growth is projected for 1992.

Now, at the end of the last session, we spent a fair amount of time in here and on the floor of the Senate trying to deal with the voluntary contributions and donations, and so forth.

And I am trying to understand, and am asking you for a little help and understanding, exactly where the administration is at right now in its relationship with the States on Medicaid. We did the provision at the end of last year where we set a new set of rules for donations and taxes.

And this question was raised at a hearing about 2 weeks ago. Everybody is sort of expecting, I think, some indication of where the administration might be at now if we do not adopt the President's plan, which is to capitate each of the Medicaid payments per en-

rollee, or per eligible person, but we are still stuck with the current system.

What is the current administration position on our relationship with the States and what we are going to do with that, again.

Secretary SULLIVAN. Senator Durenberger, as you know, we are concerned about that very rapid rate of growth that your chart so well demonstrates.

We believe that going to a capitated system would be one strategy for forcing efficiencies in the system. We have seen this with our prospective payment system for hospitals.

As you know, since that was implemented in 1983, we have seen a significant drop in the rate of cost increase in our hospitals, with no measurable index of a drop in quality, and quality has been maintained.

And that is because I maintain that here, working in the Federal Government, there is no way we can outsmart the hospital administrators, or the doctors, or, when it comes to malpractice, the lawyers here, in trying to micro-manage the system. We need to approach it from a different way, by going to a capitated system.

Then those individuals can then use their talents to figure out, with a certain dollar amount for that individual, how they can provide the care that they need and make a profit. We have seen that occur already in a number of instances. We see it in the private sector with coordinated care programs.

I visited a company that, in 3 years, decreased their per capita health expenditure from some $5,400 per employee to $3,300 per employee, with 90 percent favorable reactions from employees.

We have the State of Arizona that has a capitated Medicaid system. It has the lowest rate of inflation; and there is access to health care for their Medicaid recipients under that arrangement.

And just a few days ago, I visited a Health Management Associates Plan in Philadelphia, working with a Medicaid population; the quality of care they are giving was actually better than what those patients were receiving beforehand. They have a high level of satisfaction with their clients, and they are actually making money. They are saving dollars for the Federal treasury, and they are making money themselves. So, that is why we are committed to that.

Senator DURENBERGER. Yes. And I would say the same thing about the program that we are experimenting with in Minnesota.

But the next question, as I understand the President's recommendations, one recommendation was to capitate, plus the fixed amount, plus CPI, plus 6 percent, and then it would decline. Was that a stand-alone proposal, or is that a recommendation that had to have the credits and so forth for other persons to go with it.

In other words, could you come to this committee right now and just recommend to us that in order to get some predictability into these figures for both the Federal side and the State side, it would be wise to simply capitate the Federal contribution?

Secretary SULLIVAN. I think it could work either way, Senator. We see this, first of all, as part of a comprehensive approach that the President has proposed. And I disagree with those who say that it is nibbling around the edges. I agree with Senator Chafee that this is comprehensive; this is revolutionary. And, indeed, I think

before we are through with this process, we will see that is true with the various constituencies out there.

However, because this is already working in a number of instances in the private sector, as I mentioned, as well as with the Medicaid program, it could stand alone.

But what we want to see in our approach is to have a comprehensive reform of the entire system. While this proposal will help with Medicaid, if we do not change the rest of the system, there will still be runaway costs that are going to burden our Nation's economy, and our businesses. We are still not going to adequately address the issue of people without health insurance. So, I would like to see all of the components of the President's plan enacted.

The CHAIRMAN. Thank you. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman. Secretary Sullivan, I very much agree with John Chafee. I hope that there is some way that there can be useful compromise reached on all of this.

I think for you to start out by saying that the approach that the President has taken is comprehensive health care reform may strain credulity a bit in terms of working out this compromise.

I have some fairly basic questions. You indicated, I think, in response to Dave Durenberger, that you wanted to see the States do better or become more efficient in terms of their managing of their Medicaid programs.

I think it was OMB's own SWAT team that took a very careful look at the Medicaid program and came up with the conclusion that about 60 percent of the cause of the increased costs was due strictly to medical inflation. And I am trying to figure out in my mind how it is that the State becomes more efficient to handle all of this. I can understand what the Feds are trying to do. What the Feds are trying to do is simply say, well, here is some money, and we will off-load that on the States, and we will tell the States to do a better job.

I think you know, Secretary Sullivan, that the States are hard-pressed, to say the very least. They have been given a number of mandates by the Congress which are hard enough for them to fund.

How is it that States are going to be able to handle this cap that you are going to put on when it is downshifted to the States, when 60 percent is the cost of health care inflation itself?

Secretary SULLIVAN. Thank you, Senator Rockefeller. Let me certainly say that we would welcome the opportunity of working with you and your colleagues in trying to get this program enacted so that we can get services for those who are currently not having good access to the system.

What we are proposing is this: we want to not simply increase the efficiency of the way we are doing things now, we want to change the way things are done. As in one illustration I used earlier, I would again emphasize the importance of having a funding mechanism for everyone—those people who are presently locked out of the system, the 34 million or so without insurance. We want those individuals to have insurance.

And through the President's proposal, patients will then come into the system early, through the "front door" through the doctor's

office or the community clinic. There that visit may cost $30 or $40 or $50. If a person waits until the illness becomes more severe, and comes in through the "back door" of the emergency room, where, in many instances, the care they receive is inferior to what they would get in the doctor's office, because the doctors' and nurses' attention is diverted to those people in that emergency room who are in shock, for example. The cost of that visit may be $250, and the outcome would be less.

So, that is how, by changing behavior, we actually get better care and at lower cost. Another part of the President's proposal, of course, is to change the cost driver of malpractice.

Senator ROCKEFELLER. Could I just interrupt on that particular point? Because you are not answering my question, but you have invited another one. You indicate that virtually all—what is it, all but 1.8 percent—of the uninsured are going to get insurance under the President's health care plan. My understanding is that of the 100 percent of the uninsured, 70 percent of the uninsured have incomes above the poverty level.

So, by that definition, 70 percent of the uninsured are not going to be availed of the full tax credit. You referred to the tax credit in your opening statement.

So, on the one hand, I would like to have you respond to how those folks—now, the tax credit goes up to 100 percent, and then gradually it goes up to 150 percent in 5 years, and then it stops.

So then the next one is the tax deduction—my proposition is that there are very few people covered; I would say approximately 14 million would be covered by the President's proposal, and the rest would be the left uninsured.

And, if I am right, that has a lot of bearing on how you would answer the question. If I am wrong, of course, you would be correct.

Under the deduction for, let us say, a family in West Virginia with an income of $28,000, the deduction that would be available to that family to buy health insurance would be about $500 to $600.

Now, in West Virginia, Blue Cross/Blue Shield is very expensive: it costs $7,000 to $10,000 for a individual policy. That is more expensive than most places.

But, on the other hand, $500 to $600 on $4,000, $5,000, $6,000 of insurance a year is not exactly covered. So, you have used the word "access to coverage."

Do you mean literally that 98 percent plus will actually have coverage, or they remain having access to coverage, as many people have access to buying a Cadillac if they would only sell their house? Which is it that you mean, sir?

Secretary SULLIVAN. It is not that kind of a trade-off, Senator Rockefeller. What we are saying is this: more than 90 million Americans would have an economic benefit under the President's plan that would help them purchase insurance.

Senator ROCKEFELLER. To take them into coverage?

Secretary SULLIVAN. Now, there is a responsibility that they have to, indeed, purchase that insurance. In other words, we are helping to make it more available. Now, for a variety of reasons, our model suggested that out of 250 million people there might be 5 million who might decide, for whatever reason, not to do that.

We do not think that is wise, nor do we think it is ideal. But we are a country that is founded on the principles of individual responsibility and opportunity. And so, with opportunities does go responsibility.

So, we are saying that our role is to help make insurance more available and more affordable, but each of our citizens also has a responsibility to do their share to help see that that opportunity is made real.

Senator ROCKEFELLER. Mr. Chairman, I will come back to that, if that is all right.

The CHAIRMAN. Sure. Senator Moynihan.

Senator MOYNIHAN. Dr. Sullivan, this committee thanks you, as always, for your concern about children and about long-term dependency, and the support you have always given us in this regard.

I would like to ask a question which is just puzzling us, and we are going to have a hearing, with respect to the research into sexual patterns.

As you know, we can now establish that of the cohort of children born in the late 1960's, almost one-quarter were on welfare before they reached age 18, and were paupers. Three-quarters, almost, of which are minority children.

And the whole behavior has obviously changed American society. The last study we had of sexual behavior with Kinsey's work, which was begun in the 1930s and was finished by the mid-1950s.

Then, in 1987, the National Institutes of Child Health and Human Development contracted for a study with the NORC at Chicago; the National Opinion Research Center; Professors Ganion and Wellman. And this was all put together and agreed to, and then somehow your office said the survey cannot go forward.

And, similarly, in May of 1991, the NICHD awarded a grant to Dr. Udri at the California Population Center, and Dr. Renfuss at the University of North Carolina to conduct a study of adolescent sexual behavior. And, again, you canceled the project in July.

And I cannot imagine, as a medical person, you would want less information about something this central. Are you having trouble getting these things cleared somewhere in the government? What is the problem?

Secretary SULLIVAN. Thank you, Senator Moynihan. Let me say, first of all, as you may be aware, on the earlier sexual survey, instructions were written, I think, 2 years ago into the language of the House Appropriations Committee instructing us not to spend dollars on a specific sex survey. So, that is part of the background.

But the other issue, I can tell you, is something that never came to my office. That decision was made at NIH with no input from me or from anyone in my office, to my knowledge.

On the first one, however, I have to tell you that, indeed, I first learned about it when I was asked a question about it. I was not aware of it before then. But when I then examined the survey, which I had been questioned about, what was of great concern to me was the way the questions were presented. They were presented in a way that, even as a mature individual who has not lived in a hothouse all my life, I frankly found some of the questions embarrassing and offensive in the way they were placed.

The objections that were brought to my attention were from parents who said they did not want their children exposed to such questions. So, primarily because of the way the questions were phrased, I felt that this——

Senator MOYNIHAN. You do feel, I take it, that this kind of work needs to be done?

Secretary SULLIVAN. It certainly needs to be done, and I also stated at the time that there was nothing to prohibit any private organization from carrying it forward in the same way it was already worded.

However, we were using taxpayer dollars. And phrased in the way that it was, which was considered to be not respectful of the sensitivities of some people, I felt that this would not be appropriate for us to go forward with it in that form.

Senator MOYNIHAN. We are going to hold some hearings and we just hope we can work this out, and look forward to having your people come up in this regard. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Grassley.

Senator GRASSLEY. Thank you, Mr. Chairman.

First of all, I think that most of us here are very grateful to you and the President for coming forth with a proposal, and I think most members, particularly those on this side of the aisle, do appreciate the President's concern that builds on strengths of our present system and trying to avoid creating an even more bureaucratic-type health care system.

However, there are some criticisms that have been made against the President's proposal, and I guess my first concern would be to build on the last question by Senator Rockefeller.

Critics of the President's Health Care Reform Plan argue that even the full tax credit which could be available to low-income people will be insufficient to pay for the average cost of group health insurance for an individual, or for a family. Your response to that, please.

Secretary SULLIVAN. Yes, Senator Grassley. Thank you very much. Indeed, if we were to continue business as usual, there indeed could be difficulties with having that sum pay for it. But what we are trying to do is to reform the system, and, among other things, to control cost.

There are several things in the President's plan designed to do that. One of them he cited in his address in Cleveland, and that is by encouraging the development of group purchasing networks that would make insurance not only more available to small businesses that had difficulty getting it, but also lower the premiums that would make it more affordable.

We also believe that a number of the State mandates individually might have some merit, but collectively have had the result of making the cost of health insurance so expensive it has had a net effect of really making insurance unavailable, and we have to look at that.

So, what we are saying to those critics, is that if we continue doing business as it is done now, indeed, we would simply be building continuing inflation into the system.

We, as a nation, cannot afford that, because we have already projected, on our current trajectory, by the year 2000, we will be spending $1.6 trillion for health care; twice as much as what we are spending now.

What we propose to do by various efficiencies is to provide a basic health insurance package for individuals. We believe that that can be done with curbs on the costs of them. Our tax proposals reflect an amount that is sufficient to make available a basic health insurance package.

Senator GRASSLEY. A related criticism is that the cost control or cost containment features will not really contain costs. The argument will go that by simply putting more money into the system, all you are going to do is spend more money. Your comment?

Secretary SULLIVAN. Senator Grassley, what we propose to do is to address a number of the cost drivers that are presently in the system. First of all, we want to introduce more competition into the system. Our coordinated care program focuses on that.

One of the provisions is that each State Insurance Commissioner would see that there are at least two or more competitive private plans available in the State at the price of the insurance credit, but with competition to bring those costs down.

Because we are already seeing, with some of the examples I mentioned earlier, such as the Medicaid coordinated care program in Philadelphia, the Health Management Associates, or the statewide plan in Arizona, the AHCCCS program, that we can have a more efficient system while we provide high-quality and even better care than many of our Medicaid recipients are receiving now.

Senator GRASSLEY. All right. You have been one of the strongest voices in the country about focusing on individual behavior and how this behavior can create health care problems and costs.

But so far, there have been only occasional articles or discussions of these things. It does not appear that it has been given the emphasis in our health care debate that it seems to deserve.

Maybe that is because those kinds of problems are harder for policy makers to influence than financing the organizational dimensions of a health care system. In any case, a couple of questions.

To your knowledge, do you have any estimates of the aggregate health care costs that are attributable to these things that you have been talking about, like substance abuse, tobacco, alcohol, accidents, high blood pressure, et cetera?

Secretary SULLIVAN. I can get that back to you for the record, Senator Grassley.

[The information appears in the appendix.]

Secretary SULLIVAN. But let me give you several examples of the impact, because I agree with you that all of the focus, up until now, has been on how we organize delivery and how we finance health care.

How do we take care of problems once they have arisen? I maintain that it is much better for us as a nation, much more humane for our citizens, and much more productive for us to work to keep our citizens healthy.

My Public Health Service estimates, for example, that if we could simply change the behavior around the top 10 causes of death in the United States in 1992, we could reduce premature deaths—that

is deaths before age 75—by a minimum of 40 percent, and possibly by as much as 70 percent. We could reduce the acute disability by at least a third.

This includes, for example, such things as young people who get injured in automobile accidents and end up with paralysis on one side and have to have rehabilitation. We could reduce chronic disabilities by two-thirds. So, the power of that is great.

On the specific issue of tobacco, we have 434,000 people in the United States who die every year—that is almost one a minute—from cigarette smoking. And it costs us some $65 billion; that is more than $1 billion a week.

So, indeed, we must look to change all of these things—alcohol abuse, drug abuse, or the fact that only 30 percent of our citizens have an active exercise program. This is in spite of the fact that we know from studies now that people who have such programs not only look and feel better, they live longer, and they have lower incidence of heart attack and stroke.

Our national high blood pressure education program that the National Institutes of Health implemented in 1972 has reduced the death rates from stroke by 23 percent, and death rates from coronary artery disease by more than 40 percent.

So, we know that there are real, significant improvements that will result from that. That is why I have been so outspoken. Health promotion has to be a continuing part of our efforts. We must address that as part of a comprehensive way to improve the health status of our citizens, and not simply continue to focus on how we pay for illness once it arises. We need to avoid the problem and keep our citizens healthy.

The CHAIRMAN. Thank you very much. Senator Danforth.

Senator DANFORTH. Mr. Secretary, I think that the Hippocratic oath says, "First do no harm," or some such thing. I do not know if the quote is right.

Let me say that my concern is that in an election year, we may be getting ready to do enormous harm; that it is a very laudable objective to provide health care coverage for those who are now exposed: the 34, 35 million people, whatever it is, who now have no health care coverage.

However, the cost of health care in America is now totally out of control. The cost to the Federal Government is out of control. When I first came to the Senate it was, 8 percent of Gross National Product. In 1990, it had reached 12 percent. It is supposed to reach 19 percent by the end of this decade. As you pointed out, the trajectory just cannot be sustained.

And I am concerned that in an election year we are going to add the popular things—the universal coverage, the things that everybody wants—and we are really not going to do an adequate job of cost containment.

In an answer to Senator Grassley, you pointed out the cost containment features of the bill. I think that they are fine, but I do not think they are enough.

But I am concerned that some of them are going to be dropped in the legislative process. For example, malpractice reform is going to be a bitter fight waged by the trial lawyers, and I would not hold my breath about the chances of success.

I do not think we should pass anything if we are not going to contain costs adequately. Let me ask you just two questions. First, did you give consideration to tax caps, and if you did, why were they rejected as part of the administration's program? In other words, you say that there should be competition, and I think that that is fine.

However, right now, by having unlimited deductions for employers, plus excluding benefits from income from employees, we are saying that the more you buy in medical insurance, the richer the program, the more the cost, the more the Federal Government is going to subsidize it.

Did the administration give consideration to tax caps, and if so, why were they rejected?

Secretary SULLIVAN. Thank you, Senator Danforth. We looked at a number of ways to finance this, and, as you know, we ended up with some 38 pages of strategies.

And, certainly the question of equity in the system was one to be looked at. But, quite honestly in the final analysis, we felt this being an election year, we wanted to at least have a plan that we could begin an honest dialogue and not be impaled on something that could stop the whole process from the beginning.

And that is why we felt that the appropriate way to proceed would be to say these are the components of the plan. There are a number of ways this can be financed, and that is why we took the approach that we did.

Senator DANFORTH. Well, thank you for a very straightforward answer. Now let me ask you the second question. Last year, when I asked the HCFA administrator, Gail Wilensky, about various options for controlling the cost of health care, she suggested that I look at the German system. Did the administration look at the German system, and if it consciously rejected it, why did it do so?

Secretary SULLIVAN. Yes, Senator Danforth. We looked at systems in a number of other countries, including the German system.

But, in the German system, we found that the Germans were actually unhappy with their rate of cost escalation in their system which is similar to ours.

So they have a similar problem there, and we felt that what we needed was another approach that would have the goals of increasing access to health care, as well as cost controls on it. So, clearly, we looked at that system. We also looked at some of the systems in other countries as well.

Senator DANFORTH. Thank you, Mr. Secretary.

The CHAIRMAN. Thank you. Senator Daschle.

Senator DASCHLE. Thank you, Mr. Chairman. Secretary Sullivan, I had a constituent tell me last week that the most important thing for us to keep in mind is not to do the easy thing when it comes to addressing the health care problem, but do the right thing.

And I fear that we are looking for the easy way to approach the problem. That is my real fear. I think the American people are now ready for something bold; something that will convince them that we are going to deal with cost containment; that we are going to deal with access; that we are going to deal with the re-allocation of resources and we are going to deal with unnecessary care and we are going to reduce the hassle.

And, frankly, while I know you would argue that this is a comprehensive approach to health care, my view is that it is almost a comprehensive list of incremental changes.

I mean, that is really what we are talking about; a number of incremental changes that, to a certain extent, may assist us in moving us down the line.

But if this were the package, and we were to pass it today, I wonder if the administration has given any thought or calculation as to what the reduction in costs next year would be.

Do you know what it would be? I mean, certainly if you would come up with this as your definitive list of proposals, this is what you want us to do, certainly you have given some thought to the impact in cost containment that it would have. What would you expect costs for health to be in 1993 as a result of the passage of this plan?

Secretary SULLIVAN. There would be significant savings, Senator Daschle, and we can get that information back to you specifically.

However, we know, for example, we have in our tort system, some $20–$30 billion of care that results from the practice of defensive medicine. Those are dollars that do not add one cent to health care or needed care, but simply serve as a drag on the system. The projected savings actually with our model between now and 1997 would be $394 billion in savings. And then by——

Senator DASCHLE. Between now and when?

Secretary SULLIVAN. 1997. And by the year 2000, it would be almost $1 trillion—$954 billion. Those are examples from the variety of strategies in our proposal that would give us more efficient care. I have maintained many times that we have enough dollars in the system, but we are not spending them wisely.

Senator DASCHLE. Well, Dr. Sullivan, let me just interrupt there. We are going to be spending somewhere close to $5 trillion on health care between now and 1997. You are telling me we are going to save $300 billion.

Secretary SULLIVAN. $400 billion. $394 billion.

Senator DASCHLE. $394 billion. I mean, frankly, are you satisfied with that? Would you be able to go out to the American people and say, there is your cost containment, now be happy with it, I do not want to hear any more from you? I mean, is that what you are doing? Your response alone confirms my concern. The fact is that we are not containing costs here. We are doing something, and I applaud you for coming forth with a marginal proposal.

But I have got to tell you, I think the American people will tell us, if that is all you are going to do, Senator Daschle, we are going to find somebody else to do it a lot better, because we are not satisfied with that. I mean, I do not know what the assumptions are, and I would be interested in knowing that.

But, in the short time that I have, let me ask you this. Do you view vouchers and deductions as cost containment?

Secretary SULLIVAN. I view that as methods to give greater access to health care, Senator Daschle. But let me also say this. With 6 percent of the world's population, we now have 61 percent of the Nobel prizes in medicine and chemistry—more than the rest of the world combined.

We have the most innovations in our pharmaceutical industry. We have other countries coming here to us to ask us how our FDA operates. It is the "Gold Standard" of the world.

We have citizens coming to this country for care that they cannot get in their countries. We do not have our citizens going to Germany, or to England, or elsewhere. Now, the point——

Senator DASCHLE. Well, let me tell you——

Secretary SULLIVAN. Let me finish, Senator. The point I am making is this: our citizens expect a lot from our health care system. They have gotten a lot.

We have problems, but, clearly, we want to have changes in our system that address those problems. At the same time, we do not want to endanger the strengths of our system that have brought us all of the advances that our citizens enjoy.

So, we have to look at ways to do that. Why don't other countries have the innovation in their bureaucratic systems?

Senator DASCHLE. Well, let me tell you, because they have made better decisions about how to allocate dollars, because they are providing more money at the bottom of the pyramid for prevention and access to care at the primary level. That is what they are doing. It was a conscious decision.

Now, I have got 100,000 South Dakotans that do not have a nickel's worth of health insurance. I have got people that pay $350 a month for insurance right now, which is more than most people in South Dakota pay on their house payment, and they are telling me, Daschle, you have just got to come up with a way with which to address costs a lot more effectively. And I do not see it here. Vouchers and deductions do not control costs; they shift costs onto the taxpayer, and we really have to address that.

So, I know I am out of time, but I tell you, Dr. Sullivan, I think we have got a long way to go. And we just have to be up front with people that there are going to be some very fundamental changes in policy in order to do it right.

Secretary SULLIVAN. I agree with you there, Senator. But what I am saying is this, I, first of all respectfully disagree——

The CHAIRMAN. Mr. Secretary, I have to move on.

Secretary SULLIVAN [continuing.] With your——

The CHAIRMAN. Mr. Secretary, we have to move along here. Now, I have four more panels; distinguished witnesses who will be quite interesting in discussing many of these same subjects. For the second round, I would like to limit it to 3 minutes. And I will ask the first question.

Mr. Secretary, the administration has presented a proposal to increase the premium that upper income individuals would pay for Part B of Medicare.

Now, income-related premiums are not new to this committee. We have been down that road before. I can recall just 3 years ago when we repealed the Medicare Catastrophic legislation because of the concern of people regarding an income-related premium.

What makes you think that 3 years later an income-related premium that increases the premium on upper income individuals would be any more acceptable than it was before, and this time when you are not talking about any increased benefits? Mr. Secretary, I bear the scars of that wound, if you want to hear it.

Secretary SULLIVAN. Thank you, Senator Bentsen. I would point out that this is different from the catastrophic legislation in this way: the catastrophic legislation had in it features where, upper income individuals pay dollars to help subsidize the insurance of others in the lower income range.

Our proposal is one where we would simply decrease the Federal subsidy from the general tax rolls of wealthy individuals—that is, individuals earning $100,000 or more.

And we would decrease it from the current 75 percent of premium costs which come from general revenues. For instance, a gas station attendant who earns $12,000 a year and who has no insurance through our tax structure is subsidizing our wealthy retirees' Medicare Part B premiums.

We propose to reduce that subsidy so that that wealthy individual will be paying 75 percent of the costs, but whose premium costs still would be subsidized 25 percent from the general tax rolls.

So, what we are proposing to do is decrease the subsidy from the general tax rolls for that wealthy individual. I am confident that a number of our seniors who have such incomes would be willing to support that, because what we are trying to do is see that that gas station attendant also is brought into the system, rather than have no insurance himself and still subsidize the Part B insurance of wealthy retirees.

The CHAIRMAN. Well, we have been down that road. It will be interesting to see.

Senator Chafee.

Senator CHAFEE. Well, Mr. Chairman, I would like to pursue that, if I might. I think this is different from the proposal that was presented in past years, because in the income-related premium in the past, the money was going into the general fund, and this is different. This is helping to pay for the overall plan.

I must say, Mr. Chairman, I am appalled at a system that we have wherein some fellow is working in a jewelry shop in Providence, Rhode Island and getting no insurance coverage whatsoever, but is paying three-quarters of Jack Kent Cooke's medical bills.

Now, if that makes any sense, then something is wrong around here. And all of us are interested in taking better care of children; all of us want to see greater immunization; all of us want to see an extension of access. And, yet, we have got this system where the general taxpayers are paying 75 percent of very wealthy people's doctor's bills. Now, is that fair?

The CHAIRMAN. Senator, you and I both were on the same side of that argument, and we finally lost.

Senator CHAFEE. Well, I think we can draw a distinction from the situation as it existed in the catastrophic illness debate. In that case, patients were not getting extended benefits for a couple of years, as you recall. I cannot remember every part of the debate, but I remember it was a sinking ship, and I think you and I were the last ones off the ship [Laughter.]

Now, I think you can make a very, very strong case for this particular situation, and I commend the administration for bringing it forward. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Senator Durenberger.

Senator DURENBERGER. I will pass in favor of my colleagues.

The CHAIRMAN. All right. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman. Mr. Secretary, I guess I just need to say that I really agree with Tom Daschle. My own thought is that we are going to be closer to $1.8 trillion or $2 trillion by the year 2000.

And that, somehow, as Senator Danforth suggested, if we are going to get into a year where we are defending our own packages and pretending that they are perfect; if I do that with my approach and you do that with your approach, we are not going to get anywhere.

And, we have to tell the truth to each other. We simply have to be able to do that. The public has the right to understand that we are using common figures.

A moment ago, you said to Senator Danforth—you were talking about the German system. The German system has 100 percent of its people covered.

I am not trying to say that we should duplicate the German system, because we are not Germans. It should be an American system which is simply made better than the one we have for our own people in our own way. But to say that the rate of per capita increase for health care costs in Germany is rising at the same rate as it is in the United States is absolutely wrong.

It rose at 21 percent over from 1980 to 1989 in Germany, and it rose at 49 percent in this country. You cannot do that in public policy and expect to get reciprocity and good faith from our side.

I perfectly well understand that there are limits on what the Secretary of HHS can do. You are a superb physician; you are a superb person. I know you are trying your best.

But, for heaven's sake, when you are talking about $3,750, the only people who can get that in this country for the tax credit—and you referred to it as access, and economic benefit, and individual responsibility—are the ones who have incomes at 100 percent of poverty.

If you make over 100 percent of poverty, you do not get that kind of credit. If you make over 150 percent of poverty, you get much less than that.

I mean, what do you expect these people to do with that? You put forward benefit packages for $3,750, which only those with incomes below 100 percent of poverty could get, and they are minimalist benefit packages. You have ratcheted them down to make them equal to that amount.

You talk about a deductible. Now, I really would ask for a written answer on this.

[The information appears in the appendix.]

Senator ROCKEFELLER. I want you to answer me what is it that I say to the $28,000 median income West Virginian. And, remember, we are talking about two-thirds of all of the uninsured people who work every single day.

But you are going to give him or her $500 to $600 under the deduction, and for that he has got to go out and buy $6,000, $7,000, $8,000, $9,000 worth of insurance.

How is that individual responsibility going to carry him from $600 to $7,000? Is economic benefit going to carry them? What is he meant to do? What is that family meant to do?

Secretary SULLIVAN. Senator Rockefeller, as I indicated before, we arrived at the figure of $3,750 for a family, or $1,250 for an individual after broad consultation with the experts—our health care actuaries in this field.

Senator ROCKEFELLER. But you do not disagree with my figure. You do not disagree with my figure that only those who make less than 100 percent of poverty qualify for that $3,750 tax credit. You do not disagree with that?

Secretary SULLIVAN. No. But what I am saying is this, that we have two mechanisms here to help finance. Now, to be sure, those other individuals have a responsibility to participate in the purchase of their insurance.

One of the problems we have in our system now, Senator Rockefeller, I think you would agree, is that in many instances, both in public and private systems, we have removed the awareness of the cost results of our decisions. That is one of the reasons that we have seen such great levels of inflation. Others have come up with other proposals to address that.

What we are saying is that the role of government is to help those individuals who are most in need; for those who, indeed, can contribute to their own health insurance, that is appropriate. That is the way it has always been.

So, what we are saying is let us build on the system that we have now. Our system is innovative, and it has brought us many advantages.

One of my concerns is if we have a totally government-run system, we will have a bureaucracy that is three to four times the size of our current Medicare bureaucracy.

Senator ROCKEFELLER. Please do not do me the discourtesy of saying that what I have been talking about is a government-run system. You know perfectly well on the Federal Health Expenditures Board there is not one single government official, and the Secretary of HHS would only be ex-officio.

So, do not throw government-run, socialized, nationalized medicine at me when I am trying to put out a comprehensive plan. It may not agree with yours, but let us tell each other the truth about our plans.

Secretary SULLIVAN. Senator Rockefeller, you have not heard me use the word socialized medicine at all in characterizing——

Senator ROCKEFELLER. Well, it was your boss.

Secretary SULLIVAN. Well——

Senator ROCKEFELLER. I apologize, Mr. Chairman. My time is up.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Yes. Just a word, Dr. Sullivan, in query, about a group that once had socialized medicine and does not anymore.

And if you go back 30 years in Washington, the big health issue was the proposition of de-institutionalization of the mentally ill.

The protocols had satisfied us that schizophrenia has a pretty common incidence in any large population, we had just developed the first tranquilizers. And we set out to empty out the mental institutions.

In the last bill signing of President Kennedy's Administration, when he signed the Community Mental Health Center Construc-

tion Act of 1963, we were going to build 2,000 of these by 1980—we built about 450 and forgot.

And the mental health population in institutions is about 15 percent today of what it was when President Kennedy signed that bill.

And, yet, we have not made provisions for local care. We have not thought about going back to institutions. And we looked up, and all over the country, schizophrenics are sleeping in doorways and grates. We call them homeless.

Have you been able to think about that to any purpose that satisfies you? I just ask you as a medical man.

Secretary SULLIVAN. Senator Moynihan, that represents a very difficult problem for a variety of reasons, but, among them, of course, is the question of the individual rights of citizens.

As you know, at one time, the Mayor of New York wanted to have a homeless individual who seemed to have difficulty fending for herself placed in a shelter. She resisted that and won in a court case her right to stay on the street.

So, there are very complex issues here that we certainly want to do better than we are doing in addressing the problem of all of the homeless, including the homeless mentally ill. But it clearly is a very difficult problem, because there are so many different issues that are involved in that.

Senator MOYNIHAN. Could I just leave with you the thought, sir, which must have occurred to you anyway, that government helped bring about this proposal. I was involved in those meetings.

By over-estimating the efficacy of the new tranquilizers, by over-estimating the willingness of people to have small mental institutions in their neighborhoods, we helped create the problem of the homeless. And we had, I would suggest, a certain responsibility on us to keep thinking about it, at least.

Secretary SULLIVAN. I am very concerned about that, Senator Moynihan. I happened to serve as the Vice Chairman of the Interagency Council on Homeless, as Chaired by Secretary Kemp, because his agency provides the shelter part of housing; we provide many of the services.

And one of the ongoing tasks that we have is to try to identify Federal properties that can be made available for the homeless.

And, of course, among other things, we have run into all kinds of laws and difficulties in making properties available. But we are making progress, though not as much or as fast as we would want to.

Senator MOYNIHAN. I thank you. But I just leave the thought that the problem of the homeless is not a problem of housing; it is a problem with schizophrenia. Instant diagnosis.

The CHAIRMAN. Mr. Secretary, you have participated with us in some 2 hours of questioning.

Senator DASCHLE. Mr. Chairman.

The CHAIRMAN. Oh. Senator Daschle. I am sorry.

Senator DASCHLE. That is all right. I do not mean to interrupt, but I thought you were going to cut——

The CHAIRMAN. Thank you. No. You are quite right.

Senator DASCHLE. All right. Just for the record, I think it is important: according to the General Accounting Office, Germany experienced a 21.9 percent increase over the last ten years in health

care; ours over the last 10 years is 48.1 percent. So, I think I would be interested in the Secretary's comments for the record.

But let me just go back and clarify. I thought your answer to my question about cost reduction was very helpful, because I had not seen that figure before. But that represents a decrease in cost of one-tenth over the next 5 years. And I do not want to put words in your mouth, but I hear, from what you are telling me, that you are satisfied with that. That is it.

I do not see any other proposals out there to do more, so I have to assume that that is the administration's plan; to reduce it by one-tenth of the overall costs that would be incurred over the next 5 years.

Secretary SULLIVAN. Senator Daschle, I think almost $1 trillion in savings is not minuscule.

Senator DASCHLE. Now, wait a minute. You just said $394 billion.

Secretary SULLIVAN. $954 billion between now and the end of the decade; $394 billion between now and 1997.

Senator DASCHLE. Which is a 10-percent reduction.

Secretary SULLIVAN. Those are the dollars, which I consider significant. Now——

Senator DASCHLE. You estimate—let me just ask you, in the very brief time I have——

Secretary SULLIVAN. Can I finish answering your previous question before you go on to the next one?

Senator DASCHLE. I have got very little time. I am interested in getting as much information as I can.

Secretary SULLIVAN. I want to give you the information, Senator, but I think that I would like the courtesy of being able to respond to your question and not be jerked around by being interrupting in the middle of my discussion.

Senator DASCHLE. I do not intend to jerk you around, and I apologize if you think so. But I am also interested in maximizing what limited time we have. What do you expect to be the cost per capita of health care to be provided in 1997, even after we incur the cost savings that you have suggested?

Secretary SULLIVAN. Senator Daschle, to suggest that we will be satisfied with what is in here is not correct. What I want to tell you is that this is beginning.

What I want to also emphasize to you is that we have a system that we want to continue to provide the finest health care in the world to our citizens.

Clearly, this is a beginning, and we would like to work with you and the members of the Congress in moving down that street. Now, you can, indeed, propose to come with a radical system, where we could lose, ultimately, the strengths of our system, and I am not sure that your citizens really want that to occur, either.

But, clearly, we want to do as much as we can to continue to provide good health care to our citizens and address the problem of access and of cost. This is a beginning. Where we are now in 1992 is different from where we started in 1965 when Medicare and Medicaid came in.

No one then predicted we would be where we are now. No one today can tell you where we will be 10 years, or fifteen years from

now. But we certainly ought to begin, and that is what we are trying to do.

Senator DASCHLE. Well, we imperil the system by doing nothing, too, Mr. Secretary, and I think that has to be acknowledged. You can imperil it just as much by doing nothing as doing the wrong thing, and that is my concern. And I thank you, and I thank the Chairman.

The CHAIRMAN. Well, it has been a good exchange, and you have had some 2 hours. And you can see the depth of the interest and the concern on this very major issue facing our country. And I am sure that my colleagues would like to continue questioning you for the rest of the afternoon, but we do have four more panels. And, Mr. Secretary, we are very appreciative of your coming. Thank you for your participation.

Secretary SULLIVAN. Thank you, Mr. Chairman.

The CHAIRMAN. Our next panel consists of Dennis Crites, who is a member of the National Legislative Council of the American Association of Retired Persons, from Norman, OK.

And my friend, Mr. Larry Mathis, who is the president and CEO of the Methodist Hospital System, Houston, TX, on behalf of the American Hospital Association.

Mr. Mathis, if you are prepared, why do we not start?

STATEMENT OF LARRY MATHIS, PRESIDENT AND CEO, THE METHODIST HOSPITAL SYSTEM, HOUSTON, TX, ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. MATHIS. Thank you, Mr. Chairman. I am Larry Mathis. I am the president and chief executive officer of the Methodist Hospital System in Houston, TX, and I am the chairman-elect of the American Hospital Association. I am honored and pleased to be invited to be here to represent the views of the American Hospital Association on the President's budget proposal.

By the way, we are well aware of this committee's interest in and responsibility for leadership in health care reform, and we, as an association, encourage you in that effort and pledge our best efforts to work with you in crafting a new system for the American people.

Reform, as I think I have experienced and heard today, is a Gordian knot. Quality, cost, and access are interdigitating variables, and when you touch one, something happens to the others. And this will take time to reform the system. We have got to deal with the system as it exists today and take immediate action.

And in that regard, I have, I think, a major message, and that is to tell this committee something that I think it already knows, and that is that the majority of the hospitals in this country today are losing money on the patients who are Medicare and Medicaid beneficiaries.

The Chairman has already said it: 6 out of 10 American hospitals lost money in 1991. That is according to the Prospective Payment Assessment Commission. The overall average loss was 3.4 percent.

In my own institution, in 1991, just looking at the numbers, we lost $50.4 million against the cost of providing care to Medicare beneficiaries.

Another way of saying that is that, for every dollar it costs us—to pay nurses; to keep the utilities on; to buy goods and services

to provide that care; for every one of those cost dollars—we received 86 cents from the Federal Government.

This trend appears to be continuing under the present system, and what we see ahead is not very encouraging. According to AHA data, in the coming year, 900 hospitals will either break even or lose up to 10 percent on their Medicare beneficiaries; another 900 will lose between 10 and 20 percent on their Medicare beneficiaries; and 2,000 hospitals—nearly one-third of the community hospitals in this country—will lose more than 20 percent. Those are frightening numbers.

The President's proposals do not provide any relief from this situation, and, in fact, his cut backs would worsen, in some ways, the financial condition of America's hospitals.

As you know, the largest proposed spending cut would come from simply pushing back the effective date of the inflation increase owed hospitals, and that would be in bad faith because the prices we are expected to pay do not hold themselves in abeyance from increases. We would be due on October 1st that inflation adjustment, and should have it.

I would also like to raise the issue of teaching hospitals, and while they are not dealt with specifically at this time, they are always an issue at budget time.

We would encourage the committee to continue to recognize those great institutions' incredible contributions to the American health care system: their unique missions of providing patient care, and of providing teaching and research are special. And, if they are allowed to weaken, then health care for all Americans will be jeopardized in one way or another.

With regard to the Medicare side, things are no more encouraging. Six out of 10 lose money on Medicare, 9 out of 10 hospitals in this country lose money on Medicaid patients.

And Medicaid shortfalls are now the fastest-growing component of overall hospital losses in the health care system. Seventy-eight cents on every cost dollar is the reimbursement, on average, received by American hospitals.

The President's reform proposal has some bright spots, and certainly the American Hospital Association salutes his leadership in making health care reform a major agenda item for the administration in health care reform.

We are delighted about that, and think it is a very positive contribution to the debate. But even those positive initiatives do not make up for the serious under-funding of the existing program.

Finally, Mr. Chairman, I would have to look ahead with you and express our deep concern about some of the conversations we have heard about the possibility of extending the Medicare methodology of payment to all payors. We believe it would be a mistake to impose a Federal, government-style, Medicare single payment system for all payors of care.

If Medicare is the role model, then all patients, we believe, would suffer, and there would be underpayments for everyone; not just the poor, the elderly, and the disabled, but for everyone.

And, in fact, if that were the case, the headache that Medicare has caused for hospitals would become an all-consuming migraine for the nation's hospitals.

We have looked at the numbers at the Methodist Hospital in Houston, and if we take as our base the costs of providing all care last year of $438 million, we would be paid less than that by $118 million. That is a 27-percent reduction.

Our institution, finally, would still be there, Mr. Chairman, but it would be a far different place than it is today, and, I think, a less desirable place, not only for all patients, but for Medicare patients as well.

If we applied the 27-percent expense reductions to our work force, we would reduce our work force by 1,900 jobs, a task that I, as Chief Executive Officer, would not relish.

Mr. Chairman, I do very much understand the difficulties that this committee has and the huge responsibility on the very complex issue that it has, but I encourage you to continue your support for America's hospitals, because, by supporting them, you also support the patients we serve. Thank you.

The CHAIRMAN. Thank you.

[The prepared statement of Mathis appears in the appendix.]

The CHAIRMAN. Mr. Crites, representing the American Association of Retired Persons. We are pleased to have you. Go ahead, sir.

STATEMENT OF DENNIS CRITES, MEMBER, NATIONAL LEGISLATIVE COUNCIL, AMERICAN ASSOCIATION OF RETIRED PERSONS, NORMAN, OK

Mr. CRITES. Thank you. Good afternoon, Mr. Chairman, and members of the committee. I am Dennis Crites, from Norman, OK. I was born in Texas, however.

I am a volunteer member of AARP's National Legislative Council. AARP is pleased to have the opportunity to discuss the administration's 1993 budget and health care reform proposals.

In a nutshell, we find the administration's budget disappointing in a number of ways. First, the modified freeze on domestic spending sends a harsh message to low-income Americans, regardless of age.

Sadly, the administration's unwillingness to use part of the money saved from defense cuts for domestic needs means that low-income and older persons are forced to bear the brunt of the cuts.

Moreover, this budget employs gimmicks and massages the numbers—actions that will only add to public cynicism about the government.

The administration also proposes reconstructive surgery on the budget process. Mr. Chairman, we really need a second opinion. Real threats to older Americans are masked under the innocuous rubric of budget process reform; notably, the proposed cap on mandatory programs.

This proposal is clearly aimed at Medicare and Medicaid, since the growth in health care costs far exceeds the general rates of inflation. Granted, such rates of growth cannot be sustained.

But, a mandatory cap on Medicare and Medicaid does nothing to address the uncontrolled growth in health care costs. It can only result in two outcomes: a lower quality of care, and more cost-shifting to the private sector.

The proposed changes in sequestration rules also threaten older Americans. Currently, entitlement programs that serve the poor,

such as Medicaid, are not subject to automatic cuts to meet deficit targets, and Medicare's sequester is limited. The administration would remove most exemptions from sequestration and completely unleash the Medicare sequester.

Older Americans will not be fooled by these arcane, technical modifications to the BEA. They are an all-out assault on Medicare, Medicaid, and the programs serving our most vulnerable citizens. Adding insult to injury, the administration again proposes to income-relate the Medicare Part B premium by tripling it for higher income beneficiaries.

This proposal does nothing to address the causes of escalating cost. It merely shifts costs onto beneficiaries who have little control over Medicare spending.

Yes, we have heard the claim that this would affect only the rich. But, Mr. Chairman, we older persons were not born yesterday; we know where this is going.

This brings me to the President's Health Care Reform Plan. AARP is pleased that the President has finally entered the debate. By doing so, the question is no longer whether there will be reform, but how and when.

The administration's proposal, however, fails to deal effectively with two major problems in the health care system: number one, access to acute and long-term care, and, number two, cost containment.

AARP firmly believes that comprehensive reform must address both of these. Make no mistake, to ensure access to health care, we must control the escalating cost.

Unfortunately, the administration's proposal completely ignores the long-term care needs of American families. All too often, long-term care is seen as an elderly benefit because they are the major users of long-term care.

This is misleading because it is the younger families which bear much of the stress, the strain, and the cost. They, too, need protection.

We recognize that providing long-term care will not be cheap, but the current financial burden placed on families—particularly the sandwich generation—is enormous. For them, the cost of financing a nursing home stay can be devastating.

As for the administration's proposed tax credits and deductions—the question is whether they are enough to purchase the insurance coverage and whether they are sufficient to reduce health care costs.

I urge you to look at the charts in the written testimony. The black portion of the circle indicates how much would be covered by the tax credits in the series of charts that are in that written testimony.

And, for an average family policy for a family with an income of $25,000, the average policy cost is $5,327. The value in the income tax deduction in the President's proposal is $563. That buys one-and-three-tenths months of coverage.

The CHAIRMAN. Well, thank you very much, Mr. Crites.

[The prepared statement of Crites appears in the appendix.]

The CHAIRMAN. Let me say that that is a very dramatic presentation, when you are talking about the value of the deduction being only $563, or 1.3 months.

I assume it is your feeling that if you get a further cut in Medicare, with the problem of 60 percent of the hospitals already losing money on their Medicare business, I assume you would think it would be more difficult for those beneficiaries to find providers that are going to treat them.

Mr. CRITES. Yes, sir, it would. The providers will disappear in increasing numbers if the cost and reimbursement do not keep a reasonable pace; nowhere near the pace of recent years.

But the cost problems faced by hospitals, nurses, and others, very definitely threaten the ability of Medicare and Medicaid to serve those for whom they are intended.

The CHAIRMAN. I was listening, Mr. Mathis, to your statement and to your concern about equity insofar as payments within the Medicare DRG system.

And, particularly, the AHA, I understand, is concerned about the redistribution of payments resulting from the actions of the Geographic Classification Review Board, to reclassify hospitals from rural to urban, or change their classification because of wage differentials.

As you know, the board's decision—after the impact of the board's decisions became known, Senator Durenberger, and I, and others asked the Health Care Financing Administration and the Prospective Payment Commission to work together expeditiously to develop new labor market definitions that more fairly reflected what the wage differentials were, and I am pleased they are working together toward that goal.

But, in the short-run, as I understand it, the AHA is recommending that the financing for payments to these reclassified hospitals be developed so they can get higher payments without lowering payments to other facilities. Well, I can understand that kind of a request, but when I look at this budget and the crunch we have, where would you suggest we get it?

Mr. MATHIS. Well, first of all, Senator, as you know, I am not full-time in health policy. I work for a living; I run the Methodist Hospital. [Laughter.]

But the AHA does have the same kinds of tough political calls that this committee and this Congress does, and it was a very, very difficult session within our own political organization to reach the decision that we could not carve up an ever-shrinking pie and hold the membership together.

So, we did say, and have had introduced a bill to increase Medicare funding to take care of the effects of a change like geographic redistribution.

I am not here to advise a body like this where to get the money, I am just here to recommend.

The CHAIRMAN. We would be delighted.

Mr. MATHIS. Well, maybe defense.

The CHAIRMAN. All right. [Laughter.]

All right. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman. Mr. Crites, I was very interested in your testimony on page 13, where you discuss the Medicare coverage of State and local employees.

And your conclusion is that, of those hired prior to April 1, 1986, an estimated 75 percent of them will eventually receive Medicare benefits through either their spouse, or a limited Medicare-covered employment; and that the AARP believes this proposal was fair and equitable, although the revenues should be used to pay for health care.

As you recall, a couple of years ago we did include those who were hired after this date, but we did not address the issue of persons hired before April 1, 1986.

Applying that same rational—something being fair and equitable—I have difficulty understanding the AARP's opposition to the people on Part B paying Part B premiums from the higher income individuals, not paying a greater percentage of that than 25 percent; with 75 percent currently coming from general revenues, which is paid for by all the taxpayers.

And it seems to me that if those individuals who could afford it, and, as you know, the President has said 125,000—and maybe it should be higher. Let us just start with 500,000. Why that individual should not pay his Part B premium, either in toto, or a greater portion of 25 percent, rather than having the taxpayer pay.

And I come from a very low wage State. As I mentioned previously, our folks work in textile mills, to some extent; they work in jewelry factories; they are relatively low income.

And their taxes are going into a general fund, and to have those taxes used to pay for someone who has an income of $500,000, to pay for that individual's doctor's bill, seems to me, a little unfair. Could you explain your rationale?

And let us assume that the additional income generated from this would go into health care, whether used for immunizations for children, or some other use.

Mr. CRITES. Certainly I would hope that it would go into health care. The opposition is not to the wealthy paying more. As you probably know, we have supported income-related measures.

The question is, does it do anything towards reducing the escalating Medicare costs for the beneficiaries who are having their premiums tripled? It simply does not do anything for cost containment. It is almost a gimmick.

Yes, most Americans, including the elderly—say if it is soaking the rich, it is all right. We simply do not see it as an adequate answer; a more comprehensive answer is needed.

Senator CHAFEE. Well, you know, we have terrible problems, as Mr. Mathis was pointing out. And you are very familiar with them.

In this excellent testimony that you gave, you pointed out some of the problems we are encountering under Medicare and Medicaid, and there are many in our society, as you well know, who are currently not covered and are not receiving proper health care.

And what I would like to do is to see if we could get those individuals covered in some way. And it does seem a very odd system where we do not have the money, we cannot afford it, but we can afford to pay wealthy people's premiums. But I will not continue that.

Mr. Mathis, how do some hospitals—10 percent of the hospitals, I think you said—make money on Medicaid, or break even? How do they ever do that?

Mr. MATHIS. Well, at the risk of being flip, they have a lower cost structure. They just do not have the same level of staff, same level of technology, or, for whatever reason, perhaps the same level of facility that would drive their costs up against what they are paid.

Senator CHAFEE. Then, they would not be teaching hospitals, for example?

Mr. MATHIS. Yes. There are various kinds of teaching hospitals; some that are very high-tech, and some that are very low-tech. So, some teaching hospitals could make money on Medicare if the cost structure is low enough.

Senator CHAFEE. Medicaid. No, no. I was referring to Medicaid.

Mr. MATHIS. Oh. Medicaid.

Senator CHAFEE. Yes. You indicated that 90 percent of the hospitals lost money on Medicaid.

Mr. MATHIS. Oh. I am sorry.

Senator CHAFEE. How could any hospital make money on Medicaid.

Mr. MATHIS. Well, two factors, sir. One is that the Medicaid program varies from State to State, and in some States it is much higher than in other States and in the cost structure of the individual hospitals. But it does, frankly, defy my ability to conceive how a hospital could make a margin on Medicaid rates in any State.

Senator CHAFEE. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, thank you very much. And thank both of you for your testimony.

I guess the most frustrating part going around listening to people either here or at home talking about these sort of things is everybody talks about cost containment and universal access, and everybody has a solution, but it is not usually somebody else's solution.

I was just making notes here. The administration wants managed care, but the Children's Defense Fund, when they get up here, says that is not the answer.

And AARP and a lot of the senior citizens we read about suggests we need to do something about getting control of doctors' fees, and there is going to be an anesthesiologist who is going to get up here pretty soon and say he cannot live on $194,000 a year.

You know, we can go on, and on, and on with this sort of thing, and it may be a frustration to all of us, but it is probably also an opportunity.

Let me just take hospitals, if I can. Larry, you represent 5,000 of them; something like that. You said a majority are losing money; the average is 3.4 percent.

But maybe you can help us understand a little bit about what losing money really means. As I understand the way hospitals work, every hospital sets its own price.

And, from our standpoint, each of us goes in to get an appendectomy or get a fracture repaired, but it costs a lot more or less, depending on what hospital you go to.

And John Chafee asked you that question regarding Medicaid, and maybe I can ask you that question regarding Medicare. You

just happen to represent 60 plus percent of all these $821 billion we are going to spend this year, so let me put you on the spot and let you answer the cost containment question. I mean, without pointing to somebody else in the system—unless it is the doctors, because it is the doctors who decide who is going to come into your hospitals——

Mr. MATHIS. Sure.

Senator DURENBERGER. And maybe you want to point to the doctors—and it would not bother me a bit if you did—but try to help us understand. You have got 60 percent of the action.

Everybody wants to contain the costs, and everybody is going crazy. Look at where those lines are going for moms, and kids, and stuff like that, to say nothing of the elderly. Just look at those.

But you have got 60 percent of the dollars. Maybe you can help us understand this a little bit. And, to be fair to you, I just want to tell you briefly my experience after I left you. And Larry was kind enough to invite me down to Methodist to speak to a bunch of doctors at 7:00 o'clock in the morning. They were all awake; I do not know if I was.

But I went out and talked to some other folks around, and the interesting thing to me was to ask the people in, I think it is the Memorial System, which is, I do not know, a dozen or so hospitals.

And they are sort of on the edge of the city, but not quite in the suburbs, and they have got some small town hospitals. And I asked them the question about what Medicare paid, and they showed me: 51 percent of their charges.

I thought, oh, my God, this is awful. Medicare pays the same thing all over the country, relatively speaking. Why should it be 51 percent here? So, then I said, what do the indemnity plans pay? And they said, 163 percent; 163 percent. The HMO's pay 138 percent. So, we have that variety.

Then I said to them, compared to the big downtown hospitals in Houston, what are your charges? And he said, well, we are probably about 10 percent under the folks downtown.

Then I said, compared to the folks in the suburbs at the for-profit hospitals—because I had read Bogodonich's book—what, by comparison, are your charges with them? And he said, we are 25 or 20 percent. Let me be conservative. I think it was a higher number. We are 20 percent under those boys.

Now, you tell me why there is not some responsibility somewhere in this country on the hospital system to get these costs under control? Do you think the poorest people are in the suburbs of Houston? Do you think all the technology is out in the suburbs of Houston?

I thought I saw it all downtown where you are, where the MDM Cancer Center takes every poor person in the whole of Texas if they cannot pay their bills. Now, where are the hospitals going to be in this cost containment business?

Mr. MATHIS. The question that you pose is the question that the hospitals, as a group in this Nation, have been wrestling with for a long time.

The incentives have always been for the nation's institutions to institutionalize people and then meet the needs of those individual

human beings and their physicians to the very best of their institutional capabilities.

That is the system, those are the incentives. And hospitals today have not seen a change in those incentives, Senator. We are all still trying to do the very best we can to carry out those physicians' orders and meet the expectations of those individual patients. And I think a place like mine does it very, very well. And I think the Memorial System, and all the community systems across the country are trying to do that very well.

But what we concluded is that if cost containment is more important than access and more important than quality, or, at least now is more important, the system has to be changed. The system has to be changed.

So, we have concluded that major overhaul of the system is what we advocate and what we will work with everyone up here to change.

Senator DURENBERGER. But it seems like the ideal, if I pay Medicare and Medicaid in Houston, I ought to send everybody to the Memorial Hospitals. If they are the least expensive and the quality is the same, I should send all the business there.

Mr. MATHIS. That is not true.

Senator DURENBERGER. But Mr. Crites would not let me do that for Medicare. I mean, if he is living out in the suburbs, his folks want to go to the suburban hospitals. Right?

Mr. MATHIS. If you are paying only one rate, you should send them where you think you would get the best quality care.

Senator DURENBERGER. Yes.

Mr. MATHIS. You would have to make that decision.

Senator DURENBERGER. But if I could get a better rate at the Memorial Hospitals——

Mr. MATHIS. But you cannot with the single payor system, and Medicare is a single payor system.

Senator DURENBERGER. Well, let us say we get off of that.

Mr. MATHIS. All right.

Senator DURENBERGER. Let us say that the best cost containment is to ask everybody to go to the least expensive, high-quality hospital. So, I say they are all the same in Houston; they are all terrific—the best there is in the country.

But this one is 10 percent under this, and the other one—this is the lowest priced one for the—why should I not go there? Why should I not send all the business there?

Mr. MATHIS. Well, the program has begun to do that in heart transplants and other transplants. But let me say that, in addressing the questions that you are asking, we arrived at the conclusion that the system must be changed and that hospitals have to change as well.

And right now and the Regional Policy Boards of the American Hospital Association are working on a system of regional networks funded on a per capita basis.

That sort of system change will change the incentives. And if we can change the incentives, we will get some degree of cost control. I am encouraged by what I see happening in terms of our own response to that kind of question.

Senator DASCHLE. The Chairman had to excuse himself for a brief period of time, and has asked that I Chair in his absence.

Let me just, first of all, Mr. Mathis, compliment your association on the statement of principles that I saw a couple of weeks ago. I was surprised that it was not part of your testimony, because I really think that it addresses the issue, as you indicated.

It is a comprehensive set of principles that, in my view, would go a long way to addressing the problems we have in health care. I think everyone recognizes that the problems go beyond cost and access.

I think there is a fundamental problem with allocation; the fact that we are spending 20 percent of our dollars on paper work, on administrative costs; that we are spending on top-of-the-pyramid care when we ought to be providing care at the base of the pyramid for preventative and primary care; 30 percent of our procedures are unnecessary and we have got to deal with that structurally; and just the hassle that I hear so many of your administrators tell me about; the frustration level.

But what I am told by everybody is that there is no way we will ever address any of the problems until, first and foremost, we can convince the American people we have addressed cost containment.

And I would just like to offer an open-ended question to both Mr. Crites, and you, Mr. Mathis, based on what you know today, and the consensus—to the extent there is one in your associations—how, in your view, do we address cost containment in a macro-economic way?

I am not talking just about the Medicaid/Medicare facets of it. But were we to just completely start over—let me begin with you, Mr. Crites—how would we, according to AARP, contain costs effectively?

Mr. CRITES. The method would be somewhat similar to the method that was used in West Germany. I presume now it is used for the unified Germany.

And it would be essentially the setting of a budget—a budget that would permit reimbursement at the rates, in accordance with inflation, of Medicare reimbursement at the present time.

It would be negotiated with the States, the States would negotiate it with the health care providers. The important thing is that there would be a budget, and the providers would have to work within the budget provided.

Senator DASCHLE. So, your organization supports either a modified or a single-payor plan that requires negotiation of a global budget. That is a fair statement of your position?

Mr. CRITES. It is a single-payor plan, with the option that employers could purchase insurance from the private sector.

Senator DASCHLE. I see.

Mr. CRITES. Those who are associated with HMOs and similar organizations may want to do that; they maybe have a group plan that would provide more than the basic coverage, and they would be permitted to do so. But the basic assumption would be within the budget.

Senator DASCHLE. Mr. Mathis?

Mr. MATHIS. In the short-term, there are any number of things that could be done to cut costs, and some of them could be man-

dated, some of them could be Federally-mandated, some of them could be in the competitive arena. But I am not anywhere at all optimistic that costs will be contained in health care in this country in the far term. If you look at——

Senator DASCHLE. In the far term, or in the near term?

Mr. MATHIS. Far term. If you look at our growing population, you look at our aging population, and if you look at what is done to those people, every time a life is saved, that life is saved to interact, once again—and probably expensively—with the health care system.

If you save someone from heart disease, you have saved them to contract cancer. If you remit the cancer, you have saved them to live on, at great expense, with Alzheimer's. I do not believe that there is going to be any long-term cost containment, as long as we are successful in treating people in this country.

Senator DASCHLE. Well, but certainly your desire is something other than that, and, I would assume, that of your association; given the fact that I suspect that just about everyone would tell you that if you cannot contain costs, it really does not matter what else you do. That seems to be the driving motivation for reform in virtually ever segment of the economy. Go ahead.

Mr. MATHIS. Cost is a concern, but I will tell you, I come from an institution which sees people from every State in the union every year, and from more than 80 foreign countries.

And the people that come to us from those 80 foreign countries are flying to Houston, TX and the United States of America to buy an American product with cash.

It is a product that is seen as value, and it is seen as high quality. And people in America see that, too. So, I do not think you can take just cost and take it alone without being very concerned about what you do with quality.

Senator DASCHLE. Are you arguing that you affect quality by containing costs in all cases?

Mr. MATHIS. I think I am arguing that quality is very expensive.

Senator DASCHLE. Well, I guess quality is measured in a lot of different ways. Obviously, access to health care is a function of quality.

And, by that standard, we are not doing very well. You know, one could look at infant mortality as a function of quality, and by that standard, 20 other countries are doing better than we are.

You could look at it by what it is costing as a percent of GNP and what effect it has on our competitiveness. And by that one would argue that it is probably really not doing very well today.

So, there are a lot of different standards by which we judge quality. Certainly in terms of technology, there is none finer. But that is only one criterion, and I guess the question is what is the most definitive criteria by which we judge quality in this country.

Senator Chafee.

Senator CHAFEE. I just have one question. What do you do with a patient who, when the doctor says, well, I think I will have an X-ray taken of this, and the patient is wise and knows that there is something better than an X-ray—namely, an MRI, for example—and so the patient says, no, I would like an MRI. And the doctor

is caught in a little bit of a squeeze because, well, maybe the MRI would be better.

Now, would it probably be 10 times as much, or would it be certainly five times as much as the X-ray?

Mr. MATHIS. At least.

Senator CHAFEE. What do you do? How do you hold down costs in that situation?

Mr. MATHIS. Well, the hospital follows the order of the physician. If the physician chooses an X-ray, we X-ray the patient. If he chooses an MRI——

Senator CHAFEE. No. I am talking about the system. I am not asking you solely as a hospital administrator, I am asking you also as one who is deeply involved with the system. Can the doctor say, no, an X-ray is good enough, and that is what you are getting; it is $45 and you are not going to get a $500 MRI, or whatever it costs?

Mr. MATHIS. It is a very complex question, and it is like many others. If the physician is on a capitated payment system and is relatively free of malpractice concerns, and all of the other things that go into that kind of decision-making, perhaps it can land on the least expensive alternative.

Senator CHAFEE. But chances are——

Mr. MATHIS. But the incentives right now are not for him to choose the least expensive method; they tend to push him to the more expensive method.

Senator CHAFEE. The most expensive method.

Mr. MATHIS. Perhaps.

Senator CHAFEE. Thank you. Thank you, Mr. Chairman.

Senator DASCHLE. Thank you, Senator Chafee. Senator Durenberger, did you have any further questions?

Senator DURENBERGER. Yes, Mr. Chairman. Just to amplify on where both of you left off. I just discovered my 85-year-old father down in Florida has prostate cancer.

So, I called his urologist, and the guy is just a terrific person on the phone, and he goes through the whole thing with me and explains what it is all about. And he says, at his age, he is going to die of something else rather than prostate. Made me feel real good.

Then I thought, well, as a favor, I will let him beat up on me. So, I said, you know, tell me about RBRVS. [Laughter.]

And he did not break stride. He said, first I have got to tell you about the fact that we have been cut, and he went through some resection problem. He said, that is a so-called high-priced surgery, so we have been cut 50 percent already by you guys in the last 3 years. And then he mentioned a few other things.

But then he got to the point that John Chafee just made. He said, you know, we are going to still take assignment. A lot of people around here are not taking assignment. A lot of the Florida doctors are all mad about RBRVS, but we are still going to take assignment.

But, he said, the really hard thing is when your dad or somebody else comes in, and they have got this clipping from the newspaper, or they got the story from the guy next to them in the trailer park, and they have just discovered the latest whatever-it-is, and, by God, if it is covered, they want that coverage.

And I wanted to fortify John's question, because it is very difficult to deal with, but it had better be dealt with. I mean, there is no question about it, or we will not do this.

And the Mr. Chairman, in connection with the issue of quality, talks about access being an element of quality.

And it reminded me that another experience I had in that day in Houston was going over to Texas Children's, and they just had whatever the Asian flu version this year is—the big flu epidemic, you know.

And the emergency room at this hospital, of course, is flooded immediately. Access. All right. I mean, they are just stacked, practically, until they have to go on "drive-by."

Because everybody who is sick is so used to using the hospital, the good old, 440-bed, wonderful Texas Children's Hospital, with fame all over, is the place to get their health care. So, they have got the access. But then they have got to go on drive-by, which means you cannot go here, you go to someplace else.

But, in Houston, as in all of our communities, they find a place, do they not?

Mr. MATHIS. That is right.

Senator DURENBERGER. I mean, this notion that only in America, you know, you cannot get access to health care. That is not true. Somebody is going to find a place, even for the person with the sick kid. That does not happen all the time, but it happens most of the time in America.

And I think, as we struggle with what do we want, and what do we put our values in, and what do we call quality and something else, we had better remember that unless we change the way in which we, as consumers, use these facilities, we are not going to get control of these costs, either.

Mr. MATHIS. You may have even been the person who said it, but Americans have a lot better access to health care than they do to health care insurance.

Senator DASCHLE. I think the question is where do they access along the line of the severity of the need. I mean, the problem is, oftentimes, from what limited experience I have had, is that they wait until the end.

And prenatal care is the best example. You have a lot of pregnant mothers who do not have access to prenatal care, and it is only after birth that they come to the realization that, had they had prenatal care and availed themselves of whatever access they would have had, they could have avoided the complications and ultimately the extraordinary cost of having a child who is a result of a complicated pregnancy.

So, it is where along the line of care provided do they get that access. And, unfortunately, we tend to wait until the emergency stage before they get that kind of care.

Mr. MATHIS. I agree.

Senator DASCHLE. Well, thank you both for your excellent testimony.

Mr. MATHIS. Thank you for having us.

Senator DASCHLE. It is a pleasure.

Mr. CRITES. Thank you.

Senator DASCHLE. Our next panel will be Joe Liu, on behalf of the Children's Defense Fund, and Gary Stangler, the director of the Missouri Department of Social Services from Jefferson City, MO. If you gentlemen would come forth, we will welcome you and invite you to proceed with your testimony. We thank you for coming. Mr. Liu, since you are first on the list here, why do we not begin with you?

STATEMENT OF JOE LIU, SENIOR ATTORNEY, CHILDREN'S DEFENSE FUND, WASHINGTON, DC

Mr. LIU. Mr. Chairman and members of the Finance Committee, the Children's Defense Fund appreciates this opportunity to testify regarding the President's proposed Medicaid spending reductions.

Essentially, the President has repackaged in a more attractive hat box the Medicaid cap proposed by President Reagan and rejected by Congress 11 years ago. It was dismissed then as poor policy, and it should absolutely be rejected again.

The proposal to cap acute Medicaid expenditures for the "non-elderly" is nothing less than a direct attack on the portion of the program comprised almost exclusively of women of child-bearing age and children; the poorest, least expensive, and most vulnerable beneficiaries.

As employer coverage has grown increasingly fragile in this country for children, their dependence on Medicaid has grown equally fast. Medicaid now finances between 30 and 40 percent of all births in most States, and, in some States, that figure approaches 50 percent. One out of three children under age 6 in the United States is now eligible for Medicaid.

Despite the enormous role of Medicaid in the health of America's children, the President proposes to significantly reduce program outlays for women and children. He would accomplish this by setting State-by-State per capita limits on acute health care expenditures for the non-elderly.

Potentially included in the list of acute health care services for the non-elderly are: prenatal care, hospital and medical care for sick newborns, immunizations, checkups, doctor and clinic visits, eyeglasses, and many more essential health services simply too numerous to mention.

In other words, under the guise of acute care for the non-elderly, is buried virtually the entire portion of the Medicaid program devoted to women and children.

This is already the smallest part of the program, with the least amount of growth. The only truly significant spending growth occurring in this population now is because of case load growth. Fortunately, the President does not propose to limit case load growth.

The per capita spending limits in the President's plan would be based on States' 1992 per capita outlays. Since there is no definition of acute care in the Medicaid statute, it is unclear what the President means and what the scope of this cap is.

We presume that all non-institutional expenditures for women, children, and other non-elderly persons would be subject to the per capita limits, but it is impossible to know for certain what types of institutional expenditures would be swept in as well.

Beyond its dangerous ambiguity of scope, the cap growth limit limits States to their 1992 Medicaid outlays. This means that States' already inadequate provider payment levels will be locked in for all time.

A per capita cap adjusted only for inflation also means that Congressional reforms in 1989 and 1990 legislative sessions aimed at improving payment to community and migrant health centers and providers of obstetrical and pediatric care would be virtually unenforceable.

Moreover, while the cap methodology proposed by the President allows for case load growth, it provides no room for other kinds of real spending growth. A State could never add new services or increase the scope of covered services for women or children.

Particularly vulnerable under this proposal are the major reforms in the Early and Periodic Screening Diagnosis and Treatment program, which this committee sponsored only 3 years ago.

Many States are now in the process of adding these new Medicaid benefits for children, and the cap would essentially halt all improvement.

The President claims that these per capita expenditure ceilings, as fundamentally depressed and as structurally flawed as they are, nonetheless can be maintained in a responsible fashion without hurting beneficiaries by turning to managed care. Indeed, the caps have been proposed as a way to push States towards managed care plans.

We simply do not understand why anyone would suppose the responsible managed care providers in HMOs, who have rejected Medicaid participation because of depressed reimbursement levels, would want to jump in now.

Study after study has shown that managed care, while potentially of great benefit, saves no money, except, perhaps, in some one-time savings with overly generous plans—certainly not the case with Medicaid.

And, indeed, by improving access to health care, managed care can result in short-term spending increases as volume and intensity initially rise.

Thus, the true means by which managed care is meant to save money in a Medicaid context is through the reduction of services. There is nothing wrong, and, indeed, everything right with managed care.

Managed care programs that assure a medical home for all children and pregnant women would be a real blessing. But it is essential that initial investments be made to attract high-quality providers.

Managed care is a quality initiative, not a cost savings measure. It is also essential to build in protection for providers such as community health centers, public clinics, and public hospitals, because no health provider which is obligated by law to serve all patients regardless of their ability to pay, can take on risk.

In sum, the President's Medicaid proposal represents a thinly-veiled attempt to cut spending on the least costly services for the least costly and most vulnerable population.

This is not to say that the proposals would be acceptable if they were broadened to seniors as well; it is simply unthinkable to make

the health care program pay for health care expansions for other poor people. This is health care redistribution at its worse.

It would be much more sensible to simply expand Medicaid in a straightforward fashion, as proposed by Senator Chafee, and, at a minimum, benefits should be extended immediately to all poor children under age 18, as Senator Bentsen and other members of this committee have long proposed.

Senator DASCHLE. Thank you, Mr. Liu.

[The prepared statement of Mr. Liu appears in the appendix.]

Senator DASCHLE. Mr. Stangler.

STATEMENT OF GARY J. STANGLER, DIRECTOR, MISSOURI DEPARTMENT OF SOCIAL SERVICES, JEFFERSON CITY, MO, ON BEHALF OF THE AMERICAN PUBLIC WELFARE ASSOCIATION

Mr. STANGLER. Thank you, Mr. Chairman. I would like to make three brief comments on the President's budget proposals and then turn my attention to Medicaid and coordinated care. I administer the Medicaid program in the State of Missouri.

There is a proposal for a Medicaid facility certification fee that we oppose because it is a cost-shifting from the Federal Treasury to the State Treasury, and we in the States have become very wary of cost-shifting from the Federal Government to our treasuries.

Secondly, a simplification of eligibility, we all talk about it and support it, but we are not very good at doing it. As we in Medicaid try to aggressively to move into schools—especially with the EPSDT program that Mr. Liu mentioned—eligibility gets to be a bigger barrier than some of the other things we deal with.

Thirdly, audit and disallowance reforms. Senator Chafee and Senator Riegle have sponsored an important bill that I would urge this committee to support to help us on a very unglamorous but important issue for the States.

On the notion of coordinated care, States, in general, are very supported of it. Some of my colleagues in more rural States have some difficulties, but primarily the issue for me is the ability to get medical care to children and mothers.

Access is something we all talk about, and it does little good to have a Medicaid card but not a provider. I run a managed care project in Jackson County, Missouri—which is Kansas City—and we have not cut costs, as Mr. Liu mentioned, but we have contained costs; we have very high satisfaction levels; and we have lowered the use of the emergency room.

As Senator Bentsen and others have noted here today, emergency rooms are big cost factors, and little kids go there because they have earaches, tummy aches, and colds.

We can do a better job of getting those kids into a better system with a managed care approach where I can coordinate people with certain providers. I would like to be able to do that. Contrary to my colleague talking about States being pushed into managed care, we are trying to get there.

What we want is the shackles taken off. One of the Senators earlier questioned, well, what is the tradeoff for this per capita expenditure with GNP, or CPI plus 6 percent, et cetera.

The trade-off is to allow us to move aggressively into the area of managed care where I can target those high-risk kids in the inner

cities and I can lock them into providers and I can make sure there is follow up, and there are certified nurse practitioners, et cetera.

I would like to be able to do that through a State plan option, as Senator Durenberger has proposed, along with Senator Moynihan, instead of the cumbersome, rigorous, expensive, and time-consuming waiver process.

Senator Daschle, you have asked many times what do we really do about cost containment. In my mind, the only real, effective cost containment measure is primary care.

It is the only way that we are going to make any real inroads into the cost of health care given, especially in my State, an increasing number of elderly, and the increasing cost of health care due to technology and inflation. Medicaid is going to pay for almost half the babies born in my State this year. In another year, the percentage will be over half, and we are going to be paying for over half of all the pediatric care that kids get in my State. I have got to have a better way to organize that delivery system.

And we talk about how Vermont is different from Texas, or California; St. Louis is different than Southeast Missouri and Kansas City is different than Northwest.

I need to be able to target in those areas. I need to be able to mix and match with hospitals, and doctors and clinics, and fee-for-service, and things of that nature.

You made an earlier comment about we need a comprehensive system, not piecemeal. What I would argue we need in Medicaid is the piecemeal incremental approach. Let me try to experiment. Let me try different things. We do not have many answers for kids who are born to crack-addicted mothers. We do not have many answers for nursing home diversion, except that I would have to tell you, we cannot sustain where we are headed in nursing homes. There is not enough money printed to handle the cost of nursing homes, especially in my State.

We need a real and aggressive diversion for nursing homes, just like we did with the mentally ill, unfortunately. I would like to do it a different way.

But we know how to do that through Medicaid; we know how to arrange in-home services. And I would suggest that nobody really wants to go into a nursing home, they would rather stay with their family.

When we talk about family preservation services for children, we ought to use that same concept and apply it to the elderly in this country.

In terms of kids going into the emergency rooms because mom does not do anything until the symptoms are so bad, because of the tummy ache, because of the earache, because of the ear infection; it does not take a rocket scientist to know that asthma season is coming. We can tell every year, we sit there and we know our hospital bills are going to go up.

The kids are going to go the emergency room for their asthma, when, in July, if we had had a good managed care project; if we had a tickler; if we had a nurse practitioner who said, it is time to get Johnny's allergy shot, we could have saved that emergency room cost.

There are a lot of things we can do. The important part to me, what the President has proposed, is to take off the shackles on coordinated care. Let us try some things. We need to experiment to find out what does work in the State. I would be happy to answer any questions, and thank you for your time.

[The prepared statement of Mr. Stangler appears in the appendix.]

Senator DASCHLE. Thank you, Mr. Stangler.

Senator Durenberger.

Senator DURENBERGER. Mr. Stangler, I really appreciate the way in which you captured that. That was sort of what I was hoping Lou Sullivan was going to do when I asked him the sort of open-ended question about the President's approach to it.

I think the people in Missouri are really gifted. I know you are not paid a lot to do your work, and I know it is a big headache, putting up with everything we do to you. But I think people in Missouri are quite fortunate.

Apropos the business of primary care, and so forth. I want to bring you something I picked up. I went to an Urban Institute conference in Florida this weekend, sponsored by the Urban Institute, and Carnegie, and Nancy, and Jay, and all the people who are doing things for children.

And this wonderful young woman who used to be the health person in New Jersey, Molly Coy, who now does it for California, was there.

[Showing of flip chart.]

Senator DURENBERGER. And she was getting onto a subject that I am just beginning to learn something about, and that is, how can we get more of the health care dollars to the people that really need it—the point Senator Daschle was making earlier.

I mean, how do we keep people healthy; how do we get at the problems before they become emergency room problems and drive-by shooting problems, and all the rest of the sort of things.

I have not been able to get this in Minnesota yet; I am still working on it. But this is California. This is all the stuff we do over in the Labor and Human Resources Committee to bring better health care to our community. And it is everything at the top from Rape Crisis; and Victim/Witness and Assistance; and EPSDT which is in Mr. Liu's report; Family Violence Programs; Special Ed.; Children of Alcoholics; Child Nutrition; Newborn Screening; STD; State Pre-School; Family Planning; Migrant Child Care; Immunizations. She said in California there are over 200 of these things. She is going to give me the list of over 200.

I mean, you cannot walk into any one of our communities and find the health care because of the bureaucracies and the mandates and everything else that are built up by those of us who, in our very well-intentioned ways, are trying to get more Federal resources to all these people out there.

That is one of the things I wish the President had talked a little bit more about, too, because in California, there is $16 billion in public health monies being spent on vulnerable populations. Sixteen billion.

That sounds like a fair amount of money. But I will bet you that the people of California are not getting $16 billion worth of serv-

ices; they are getting a bunch of bureaucracy and they are getting a bunch of accountability, and a whole bunch of other things.

And I liked that so much I had it blown up so I could ask maybe both of you to react to other ways other than what had been proposed by the President to try to help us get even existing dollars better spent.

Mr. STANGLER. Senator, I would like to tell you that is peculiar to California, but it is not. It is the same in Missouri, and in Minnesota, I might add. We need to reduce the amount of chaos in the system, and your chart perfectly illustrates the chaos that faces the family. And, in my mind, coordinated care is a way to reduce that chaos.

We have hundreds of programs in the State and if our ability to get kids started in the schools—I want to turn day care centers into primary care Medicaid providers in my State, and I will do that. That will begin to reduce the chaos over the long term.

Mr. LIU. I am glad our agendas are so close. The Children's Defense Fund places a high priority on coordinating these services. Unfortunately, every one of those services listed is under-funded in significant ways.

And, by combining these services, making it simpler for parents to wind their way to get their eligibility determined in one place rather than in 20 different programs is a start.

And those are issues that we think are very important to families, but we cannot look at changing the system by simply cutting dollars.

We have to be able to coordinate it better and then look at our cost savings. We start with improving quality of services, not with cost cuts.

Senator DURENBERGER. But as the Commissioner, Molly Coy, pointed out, behind every one of these programs is a constituency. Right?

Mr. STANGLER. That is right.

Senator DURENBERGER. And nobody wants to be put in competition with somebody else for these so-called limited dollars. So, the idea of coordinated care is a wonderful thing, but it is sort of like saying to the elderly, we are going to ask you to go across town to a hospital because it is 20 percent less, or we are going to ask you to go to this doctor rather than that one, maybe, because he is just as good. It is sort of a built up resistance from the days when people did not have to make——

Mr. STANGLER. But we may have to go down that road.

Senator DURENBERGER. Yes. Thank you. Thank you, Mr. Chairman.

Senator DASCHLE. Mr. Stangler, could you clarify? You made a comment earlier that startled me. You said you are going to pay for half the babies born in Missouri?

Mr. STANGLER. We will pay for more than 40 percent this year, and we expect that next year we will pay for half the babies born through Medicaid. That is correct.

Senator DASCHLE. So, Medicaid is going to pay for half the babies born in Missouri next year.

Mr. STANGLER. That is correct, Senator.

Senator DASCHLE. That is a phenomenal figure. I had not heard that before.

Mr. STANGLER. It is staggering.

Senator DASCHLE. It is that high?

Mr. STANGLER. Yes.

Senator DASCHLE. How many of those, in your view, will be born with complications—what percentage?

Mr. STANGLER. It would be a relatively small percentage, but that small percentage will be very expensive.

Senator DASCHLE. That is right.

Mr. STANGLER. $90,000 to $100,000 a month is not unusual.

Senator DASCHLE. I have been told that—excuse me.

Mr. STANGLER. $90,000 to $100,000 a month is not unusual.

Senator DASCHLE. I have been told that you can provide prenatal care to up to 500 mothers for the cost of one baby born prematurely and with complications. Do you share that overall assessment?

Mr. STANGLER. I share that, and I get in trouble when I talk about this. The anomaly is that we are covering and paying for more and more mothers, and, yet, in Missouri and in many States, the rate of inadequate prenatal care is also rising.

So, yet, as I cover more and pay more, I am watching inadequate prenatal care rise. And the answer, to me, is because even with good prenatal care and 12 visits, that mom is going to continue to do crack, drink alcohol, and smoke cigarettes, and my money is not doing much.

Senator DASCHLE. Right.

Mr. STANGLER. But it is a very vexing issue. Even those issues aside, that inadequate prenatal care rises as we pay for more.

Senator DASCHLE. I was surprised, frankly, to hear you say that you think the only cost containment feature that you feel comfortable supporting today is primary care.

And I say I was startled by that because it just seems to me that when somebody comes up to me and says, today we are going to be spending somewhere between 20 and 25 percent on administrative costs in our system, that we have what I call a gas guzzling system.

Just like a big, huge car that only gets 6 miles to a gallon, to get the car from point A to point B, we have a gas guzzling health system that uses far too much money on administrative costs to get it from point A to point B to deliver health care, and that seems to me to be a prime target for savings and reallocation to primary care.

The second thing that I hear all the time is that 30 percent of our procedures today may be medically unnecessary. Well, if it is 30 percent—and Arnold Relman and others have argued that it is at least that high—I mean, that is $246 billion this year.

So, you take the two figures; 20 percent of our health care system is spent on administrative costs, say, $200 billion. Thirty percent is unnecessary. You are talking about $300–$400 billion that may be misallocated today if those figures are correct.

Now, I think you could argue whether it is 20, or 15, or 30, or 25. But, first of all, do you share the assumption by many that those are two sources of dollars wasted that could be reallocated to more important needs in the health care system?

Mr. STANGLER. I share those, too, and I could even add some. My comment was that the only effective long-term cost containment strategy is primary care. I have a capitated program in Kansas City. In a capitated program, I can drive the costs down. You give me 2 years to set up the program and I will take the President's CPI, plus six, plus five, and I will make it work—if you give me the tools to do it.

Senator DASCHLE. Mr. Liu, do you have any comment on that?

Mr. LIU. Well, I think, first of all, one of the problems we are seeing that States are picking up more and more deliveries in the hospital, but they are not paying for prenatal care for pregnant women because they present women with 30, 40-page application forms, week-long waits at welfare offices to apply for the program.

States are not implementing the requirements to out-station eligibility workers that this committee passed 2 years ago. We think States are setting up all sorts of barriers to keep women out of the system, and they only get in after the babies are born. And that is part of the shame of what is happening with Medicaid right now.

Senator DASCHLE. Well, the concern I have—and I may have misunderstood what Mr. Stangler said—is that we ought to be taking an incremental approach to deal with what he perceives to be the biggest problem first, and that is lack of access to primary care, and I subscribe to that. But it just seems to me that it would be almost impossible for us to open up the gates of access to primary care and not worry about the initial balloon on cost that would prevent it from happening.

I think it is one of the reasons why I became convinced that dealing with the health care problems in a comprehensive fashion is the only way you are going to be able to do it and get the things that we have to do done that are so pressing.

I mean, I think what you said is absolutely right, but if we do not also reallocate some of those wasted dollars away from paper work and away from unnecessary care and reduce the hassle, then it does not seem to me that we have the wherewithal, either legislatively or politically, to accomplish what you and I want to do.

So, it seems like because of the extraordinary interrelationship of all of these problems, it is almost impossible for us to address one and ignore the other and expect to address the first one successfully.

Mr. STANGLER. I understand. And, in looking at the chart, once you have pushed down on one of those, something else pops up.

Senator DASCHLE. Exactly.

Mr. STANGLER. We have case workers in hospitals; we do all these things. My second remark was simplification, and there will be a balloon when you have that primary care, and that is why I say you have got to give me 2 years to get that balloon under control before you start showing up your emergency room and acute care cost savings in the out years.

Senator DASCHLE. Do you think you will see substantial improvement in 2 years?

Mr. STANGLER. I do.

Senator DASCHLE. You do.

Mr. STANGLER. I do.

Senator DASCHLE. I think you would in pregnancies——

Mr. STANGLER. Right.

Senator DASCHLE. You would in certain areas. But I think in wellness promotion, I think I would believe there is a longer timeline there before you really see reductions, for example, in heart problems and a lot of the aggregate problems that exist because we have not emphasized wellness promotion and prevention successfully in the past. In some areas of health care I think you would see immediate results.

Mr. STANGLER. You are entirely correct on those points. I would go right after those high- cost babies, and those high-cost nursing homes right off the bat.

Senator DASCHLE. Right. Well, listen, thank you both. I appreciate your testimony. Excellent.

Mr. STANGLER. Thank you.

Senator DASCHLE. We will take the next four witnesses together. The president of the American Society of Anesthesiology, G.W.N. Eggers, Jr. Dr. Eggers is the president of the American Society of Anesthesiology. Scott Gray, of C.R.N.A., is the president of the American Association of Nurse Anesthetists.

Corrine Parver, the president of the National Association of Medical Equipment Suppliers; and Hope Foster, general counsel for the American Clinical Laboratory Association. If those people could come forward, we will begin with your testimony now.

And I will take you in the order that you are listed here on the witness list. Let us welcome all of you. Thank you for waiting as long as you have to present your testimony. We appreciate very much your time this afternoon. We will begin with Dr. Eggers.

STATEMENT OF G.W.N. EGGERS, JR., M.D., PRESIDENT, AMERICAN SOCIETY OF ANESTHESIOLOGY, COLUMBIA, MO

Dr. EGGERS. Good afternoon. I am Dr. William Eggers, and I am pleased to be here today representing the American Society of Anesthesiologists. I will summarize our written statement. And in response to Senator Durenberger's comment about the income for anesthesiologists—those days are gone.

Medicare payments for anesthesia services have been cut by approximately $1 billion since 1986, and, in spite of the fact that anesthesiologists received the largest cut under the new Medicare fee schedule—a startling 29 percent—the President's 1993 budget seeks yet another significant cut.

The budget proposes to cap payments to the anesthesia care team; that is, the anesthesiologists and nurse anesthetists working together. The cap would be at the rate of a personally administered anesthetic. This is not a new proposal, but one which the OMB has offered and that Congress rejected in previous budgets. The impact of the proposal would be severe, both as to dollars and the mode of anesthesia care delivery.

Most of the anesthetics in this country are provided by anesthesiologists and nurse anesthetists working in teams, with one physician medically directing nurses in concurrent surgical cases.

Medicare Part B pays the nurse full base and time units and the anesthesiologist reduced base units and half time units. This committee and the Congress have dealt with payments to anesthesiologists and nurse anesthetists in several budget cycles.

In 1986, Congress mandated direct Part B payment to nurse anesthetists. In 1987, Congress mandated cuts in medical direction payments to anesthesiologists which reduced base units by 10 percent, 25 percent, or 40 percent, depending on the number of concurrent procedures.

The ASA supported this provision during that budget cycle. In 1989, when the CRNA Part B payments became effective, the time units for all medically-directing anesthesiologists were cut in half to contribute to the budget neutrality of the CRNA payments. ASA supported this action by HCFA.

In 1989, OBM proposed to significantly increase the base unit reductions for medically-directing anesthesiologists. This proposal was rejected by this committee and the Congress.

In 1990, OMB again tried to cut payments to the care team, and, indeed, proposed the very same cap on payments we are discussing today.

This committee again rejected the proposal and instead extended the existing base unit reductions, which would have expired without action. Again, ASA supported the extension of current law.

In the same 1990 law, clearly knowing the impact on total payments for care team anesthesia, the Congress significantly increased payments to nurse anesthetists.

On January 1st of this year, the new Medicare fee schedule, based on RBRVS, has cut payments to anesthesiologists by 29 percent. If the proposed OMB cap were to be imposed under current law, the CRNA would receive more than twice the payment from Medicare as the medically-directed physician—the physician who is medically and legally in charge of the case.

The existing base unit reductions are, like the Medicare fee schedule, resource-based. That is, reductions are applied on a sliding scale depending on the intensity of medical direction in relation to the number of cases.

OMB's proposal discards this resource-based principal. In fact, it abandons the fee schedule itself for the majority of anesthesiologists. It would create perverse incentives that jeopardize the continuation of the anesthesia care team.

Mr. Chairman, the numbers speak for themselves: $1 billion in deficit reduction and a 29-percent budget-neutral cut. We have contributed more than our fair share to the budget-cutting process, and urge that the committee again reject the OMB proposal.

And if I may, one final word about anesthesia time. As you know, HCFA has again stated its intent, despite rather clear contrary instructions from the Congress, to move to average anesthesia time.

As a Missouri physician, I can only suggest the need for a legislative 2 x 4 to finally get HCFA's attention on this issue. Thank you.

[The prepared statement of Dr. Eggers appears in the appendix.]

Senator DASCHLE. Let me apologize to Rick Doherty. I failed to cite him as one of our witnesses; the president of the Comprehensive Home Health Care Co., in Avon, MA. We are pleased he is here, too.

Mr. Gray.

STATEMENT OF SCOTT GRAY, C.R.N.A., PRESIDENT, AMERICAN SOCIETY OF NURSE ANESTHETISTS, HOQUIAM, WA

Mr. GRAY. Good afternoon. My name is Scott Gray. I am an independent contractor and chief C.R.N.A. at Grace Harbor Community Hospital in Aberdeen, which is a rural, 100-bed hospital in southwest Washington.

As a matter of interest, our Medicaid deliveries are at 70 percent of all the deliveries in our hospital system at this time, and it is expected to raise to 80 percent by next year.

As the current president of the American Association of Nurse Anesthetists, I want to convey to the members of this committee our appreciation for the support that you have repeatedly shown for C.R.N.A.s.

We understand that you have had to make tough choices on anesthesia payment issues in the past, and will continue to have to confront Federal budget deficits in the future.

The AANA is pleased to have the opportunity to testify on President Bush's budget proposal on anesthesia services.

As the professional society that represents over 24,400 C.R.N.A.s, which is 96 percent of all nurse anesthetists who practice across the United States, we do not support the President's budget proposal on anesthesia services.

It advocates a Medicare legislative initiative that would set a single fee for anesthesia services, regardless of whether an anesthesiologist personally performs the service, or medically directs a C.R.N.A.

This overly simplistic approach to a very complicated issue has been included in the President's budget proposals for the last several years as a way to cut Medicare spending. Each year this approach has been rejected by this committee. We strongly encourage you to reject it again.

We believe that any additional changes in Medicare reimbursement policy for anesthesia services should be undertaken with great caution for the following reasons:

First, the HCFA final rule on the Medicare physician fee schedule under the RBRVS system has had a major impact on the current system of payment for anesthesia services.

In light of the dramatic 29 percent cut in anesthesia services under the new RBRVS system, we do not believe that this is the time to approve additional cuts in anesthesia of $100 million in 1993, and $925 million over 5 years.

The anesthesia payment changes that went into effect just last month should be analyzed before any additional recommendations for changes in Medicare reimbursement policy for anesthesia services are adopted by Congress.

Second, C.R.N.A.s currently provide over 65 percent of all anesthetics administered in the United States annually, according to the 1988 Center for Health Economics Research study that was mandated by Congress.

C.R.N.A.s are the sole anesthesia providers in 85 percent of the rural hospitals, affording these medical facilities obstetrical, surgical, and trauma stabilization capability.

Consequently, we would be concerned about any change in payment policy that could result in fewer C.R.N.A.s being available to

provide anesthesia. This could further restrict access to health care, especially in rural areas.

Third, depending on the payment methodology used to implement it, severe disruption to the current anesthesia delivery system could occur. Further Medicare payment reductions could result in employment shifts for C.R.N.A.s.

Fourth, there is not always an equal opportunity to compete. It is sometimes difficult for C.R.N.A.s to secure hospital/facility clinical privileges, due to a variety of factors.

Federal law would need to be amended to require that institutions receiving Medicare payment not discriminate against providers as a class in the awarding of hospital/facility clinical privileges.

Fifth, we believe that any future change to the Medicare payment methodology should have a neutral effect relative to the preparation of anesthesiology residents and nurse anesthesia students.

There should be an equitable treatment in terms of payment for the supervision of anesthesiology residents and nurse anesthesia students by anesthesiologists and/or C.R.N.A.s.

Both anesthesiologists and C.R.N.A.s should be reimbursed for providing an anesthesia service and a clinical instruction service when supervising anesthesia trainees.

I would also like to very briefly address three related anesthesia issues that we know are of interest to the committee.

First, we realize that an issue has arisen regarding the legislative intent to have the conversion factors for a medically-directed C.R.N.A. be at 70 percent of the conversion factors for a nonmedically-directed C.R.N.A. established under OBRA–90. We are studying the issue, and look forward to working with the committee to address the situation.

Second, in light of HCFA's continued zeal to eliminate the use of actual anesthesia time, we urge Congress to send HCFA a very clear legislative message that the use of actual anesthesia time should be retained permanently.

Third, the AANA is pleased that HCFA has agreed to remedy the disparity in payments between anesthesiology residents and other non-physician anesthetists.

However, we believe that equity demands that the new HCFA payment policy regarding anesthesiology residents become effective immediately rather than being delayed until 1994. Thank you for the opportunity to present our views on these issues.

Senator DASCHLE. Thank you, Mr. Gray.

[The prepared statement of Mr. Gray appears in the appendix.]

Senator DASCHLE. Ms. Parver.

STATEMENT OF CORRINE PARVER, PRESIDENT, NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS, ALEXANDRIA, VA

Ms. PARVER. Thank you, Senator. I am pleased to have the opportunity to testify before you today. I am Connie Parver, president of the National Association of Medical Equipment Suppliers, which represents over 2,000 home medical equipment suppliers in this country. With me is Rick Doherty, who is a HME supplier in Avon, MA.

Despite the critical role which home medical equipment plays in the entire home health care spectrum, and the fact that needed industry reforms currently are being considered by Congress, HME continues to be singled out by the administration for budgetary reductions to such a severe level that I am concerned that the ultimate effect may well be the dismantling of the entire HME services industry.

I would like to read a short quote from "Re-inventing Government" by David Osborne and Ted Gabler. They say, "Waste in government is staggering, but we cannot get at it by wading through budgets and cutting line items. As one observer put it, our governments are like fat people who must lose weight. They need to eat less and exercise more. Instead, when money is tight, they cut off a few fingers and toes."

I am afraid that the President's budget proposal cuts off an arm and a leg and then hands back the knife to the administration.

HME is such a small segment of the health care industry, accounting for just 2 percent of overall Medicare budget outlays; approximately $1.6 billion for fiscal year 1991.

Yet, over 14 percent of Medicare Part B payment cuts in OBRA–90—some $215 million—came from HME. And now, again, in its fiscal year 1993 budget, the administration proposes yet another series of drastic cuts that directly affect the HME industry.

These newly-proposed cuts, totalling almost $500 million by 1997, would further aggravate the industry's ability to meet the growing needs of Medicare beneficiaries.

I respectfully request that the committee examine seriously the administration's lengthy list of proposals for further significant reductions in home medical equipment reimbursement.

Particularly disturbing is the extremely broad discretionary authority that the HME provision in S. 2217 would grant to HHS and HCFA to make payment determinations for home medical equipment items ostensibly to reflect current market factors.

If those provision were enacted, Congress, in essence, would allow HCFA virtually unlimited power to effect whatever HME payment reforms it deems proper with no further guidance from, or consultation with Congress. I respectfully request the committee to reject this proposal in its entirety.

The administration notes that across-the-board reductions in home medical equipment reimbursement are "justified by numerous reports of fraud and abuse" in the home medical equipment industry. That is nothing but an appeal to emotions, unsupported by logic.

To adopt the administration's position would be equivalent to yanking your credit cards because a few House colleagues bounced checks.

To address the problem of abusive business practices, the proper response should be to target the abusers. To mindlessly reduce home medical equipment reimbursement across-the-board does nothing to punish abusers or extricate them from the Medicare program. Moreover, it punishes the legitimate HME services industry for the sins of the few.

Fortunately, you have some credible alternatives in the form of S. 1988 and S. 1736, and, on the House side, H.R. 2534. NAMES

actively supports these bills, and on behalf of the vast majority of ethical home medical equipment suppliers, calls on this committee for its support of this legislation as the proper policy response to reported abusers.

The administration's reliance on a recent GAO study purporting to indicate that home medical equipment suppliers reap excessive profits from the Medicare program is equally illogically misplaced.

A careful examination of this GAO report by an independent consultant—and I ask that the report be submitted for the record—reveals that flawed sampling and accounting techniques applied to an extremely small data sample—just six home medical equipment suppliers were surveyed, and we have over 100,000 in this country—rendered the results valueless.

The GAO findings are at extreme variance with other industry surveys, and, indeed, with other well-accepted techniques for calculating statistical reliability. The probability that GAO accurately states HME profitability ratios is less than one-half of 1 percent.

Any report evidencing high business profit margins in Medicare along with extremely large losses in non-Medicare is suspect from a common sense standpoint.

Despite the crucial fact that GAO admits it was impossible to offer projectable results due to the small data sample, the administration nonetheless relies heavily on GAO's unsupportable findings to develop its fiscal year 1993 Medicare budget for HME.

It was only last year that the home medical equipment industry sought and gained your help in forestalling implementation of HCFA's faulty HME fee schedules that were riddled with errors and inconsistencies until such time as appropriate data corrections could be made. Such actions help demonstrate the necessity for constant congressional oversight of administration activities.

The blanket delegation of authority sought by the administration in its fiscal year 1993 budgetary provisions regarding home medical equipment is unwise economic and social policy, and downright frightening.

We would be pleased to answer any questions.

Senator DASCHLE. Thank you, Ms. Parver.

[The prepared statement of Ms. Parver appears in the appendix.]

Senator DASCHLE. Ms. Foster.

STATEMENT OF HOPE S. FOSTER, GENERAL COUNSEL, AMERICAN CLINICAL LABORATORY ASSOCIATION, WASHINGTON, DC

Ms. FOSTER. Good afternoon, Mr. Chairman, and member of the committee. It is late. It has been an interesting and dynamic afternoon. I will be as brief as I possibly can.

I am general counsel of the American Clinical Laboratory Association, an organized of federally-regulated, independent clinical laboratories. We appreciate this opportunity to share with you our reasons for opposing the administration's fiscal year 1993 budget proposal for laboratories.

As you know, Medicare uses a fee schedule to reimburse clinical laboratories. Fee schedule payments are capped by a median-based national limitation amount. That cap has been reduced year after

year. It started at 115 percent of fee schedule medians; it is now at 88 percent.

The administration has proposed that the cap be lowered to 76 percent on January 1, 1993; a cut that would result in a 39 point reduction since 1986.

Although we have worked closely with you in past years to achieve equitable reductions in that cap, and while we have not opposed the proposals that brought the cap down to 88 percent, we can no longer support these types of reductions.

Given the past cuts, it should surprise no one that we find this proposed cut to be too steep and too deep. Some statistics will illustrate our point.

Since 1984, Congress has passed five different budget measures, which, when totalled, called for $3.5 billion in multi-year lab cuts. This rate is just a shade under the $3.8 billion that Medicare will spend on lab testing in fiscal year 1993.

Moreover, over the next 5 years, the administration is, in essence, asking labs to provide testing to the program for 1 year at no charge at all; as the administration's 5-year lab savings total is $3.98 billion; just about the amount that will be spent in 1993. This cut is simply too large.

The administration's budget package also asks labs to contribute disproportionately to deficit reduction. Twenty-five percent of the total 1993 savings offered by the administration would come from labs, despite the fact that labs will only account for 2.7 percent of Medicare's 1993 outlays.

Perhaps even more staggering, labs would shoulder 72 percent of the Part B provider savings proposed by the administration, even though these suppliers only constitute 5 percent of Part B expenditures.

While such a request would be unfair at any time, it is particularly inequitable, given the substantial reductions that labs have already sustained.

Laboratory testing is an important life-saving and cost-containing health care tool. It permits early diagnosis and treatment of disease.

When you go to your doctor and he draws your blood, he generally sends that specimen to a laboratory for analysis. The chances are high that the lab he sends your specimen to is an ACLA member.

When you consider your cholesterol level and risk of coronary disease, you are looking at measurements supplied by a clinical laboratory.

Given the significant medical decisions that are made based on lab testing results, it is imperative that testing be of high quality and easily accessible.

The large lab cuts proposed by the administration threaten accuracy and access, especially given the history of Medicare reimbursement reductions and the cost increases labs have experienced in recent years.

As we struggle to improve our Nation's health care delivery system, we should not choose easy answers that exacerbate long-term problems.

Lab testing today is a bargain. Medicare will spend, on average, only $56 on independent laboratory testing per beneficiary. Part B expenditures per beneficiary will reach $1,900.

Thus, testing services provided by independent laboratories will account for less than 3 percent of per beneficiary Medicare Part B outlays.

While ACLA believes that the administration's proposed lab cut represents poor policy, we do recognize that structural problems plague our marketplace and effect Medicare outlays.

These problems arise because many physicians ask for and receive large discounts for non-Medicare testing. A significant number of these physicians mark up the discounted price by a substantial amount when they bill patients and third-party payors for the purchased tests.

As with other well-documented and publicized situations like self-referral, when physicians have a financial stake in lab testing, utilization escalates, thereby inflating expenditures.

These distortions should be cured by enactment of a direct billing law which would prohibit their continuation. Enactment of such a law would allow further cuts to Medicare payment levels, and, again, would result in lower outlays. Thank you.

Senator DASCHLE. Thank you, Ms. Foster.

[The prepared statement of Ms. Foster appears in the appendix.]

Senator DASCHLE. Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman. I am trying to think of some good news. I know the bad news is anesthesiologists are going down, C.R.N.A. is going down, HME is going down. CLEA has been goofed up for a long time.

And the only good new is that it will probably last for a couple of more years, and then you will not be coming in here, you will be going to the State government, and if we adopt a Canadian system, you can go to the State government and deal with all of this.

If we adopt Health America, you will be going to something called a Professional Expenditures Control Board. If we adopt Paul Tsongas' recommendation, you will be going to something called a State Sponsor.

And even under the administration's proposal, you would be moving toward some kind of capitated system where there will be so many dollars to spend to keep people healthy in America, and some experts will decide how much of which of your services it takes to do that.

So, as I struggle with what is the good news in it, I think 10 years of sitting here and agonizing over each of these procedures, trying to weigh the value of an anesthesiologist, versus C.R.N.A., versus something else will be over for us. We will go on and do something else. But for all of you, your troubles will have just begun.

And that is a realistic statement, that is not a cynical statement at all. Because everything we have heard about cost containment from everybody else eventually gets back to the person who has to charge the bill to do the quality service, and that is the folks that are here; and Larry Mathis, the hospital person. Everybody else was an expert.

You all just have to deliver the goods and services that everybody in America wants, and they want two of them, or three of them, or four of them, or whatever the case may be.

But all of our experiences here have been with reducing payments in one way or another, and we are not adequate to the task. And so it will be taken over by some other entity, and it will not be us. That is the good news.

I wanted to say one other thing, Mr. Chairman, sort of like for the good of the order. The President is getting a lot of bad news today, I understand. I mean, nothing very good. And everybody has been, sort of by implication, saying you cannot get health care for $1,350 and you cannot get it for $3,750.

And AARP gave us this chart saying that the average policy costs for an individual is $2,445, and the average policy cost for a family is $5,327. And I want to invite everybody to come to the State of Minnesota, which has a lot of very average people, and they are just as heterogeneous as a lot of people; they come from South Dakota, or Laos, or Saudi Arabia, or places like that. We have clinics with 17 interpreters in them just like they do in Houston and places like that.

But in Minnesota you can buy from Group Health a personal care basic rate plan which is all medically necessary hospital, medical, et cetera, expenses, plus 100 percent, no deductible on preventive, 100 percent out-patient; only a $400 deductible on hospitals.

And you can buy it for $1,250 for an individual and $3,750 for a family if you are a male under 45 or a female under 35. That is the qualifier.

If you go to Blue Cross/Blue Shield of Minnesota, you can get all medically necessary hospital/medical/drug-related/diagnostic expenses for everybody under 60 with only a $500 deductible. And so, you know, it depends on where you go in America. I think our hospitals are just as good as anybody else's hospitals. I think our doctors are just as good as anybody else. We have got too many hospitals; we have got too many empty beds. We have got too much of this, that, and the other thing.

Our anesthesiologists and C.R.N.A.s are underpaid, and so forth. But somehow or other we have managed to begin to deal with some of these costs, so I am not here to say that this idea of the President's is the magic solution to the problem.

I am just here to say to people that if you really want to get about the practice of medicine and health care in an appropriate way you can do it. You can do it. Come to Minnesota and a lot of people will show you how to do it.

Unfortunately, we have still got a long way to go. I mean, we have got four bone marrow transplant centers. We do not need four of them in the Twin Cities. It is a wonderful thing, but we do not need four of them.

We are as bad as everybody else on all the MRIs and so forth. But I will tell you, I found a family medical clinic on the West Side of St. Paul that serves 40,000; mostly poor people.

And they can provide comprehensive out-patient, medical care for $196 a year, and they do surgeries, too. I mean, not the kind you have to get into a big hospital for. $196 a year. Dental care is a little bit more expensive: $230 a year.

And I give you that figure only to say that there is something wrong with the insurance system, there is something wrong with the payment systems, as everybody on this panel has articulated.

There is something wrong with a whole lot of things in this country. But just junking them and going to some other country, or just saying the President does not have a good idea, or Tom Daschle does not have a good idea—come on. Jay Rockefeller is right, we have all got to get together and we have to figure out where we go from here.

But I did, Mr. Chairman, for the record, really want to make the point that, you can buy a lot for $1,250. The plan you and I participate in as Federal employees, the voucher—the $1,250 voucher the President talks about; the $3,750 voucher—well, our voucher here for a Blue Cross family plan is $238 a month; for an individual plan it is $112 a month. That is what we get as Federal employees if we make one of those choices. So, that is $1,344 for an individual plan and $2,856 for a family plan. The whole family plan, the standard plan, costs about $3,816, you know, and that is for people all over the country and so forth.

So, I do not think the President is being—somebody called him deceitful, or something like that. I do not think he is being deceitful at all.

He is just saying if you really want to do it; if you get in here and you do this insurance reform and you start shaping up some parts of the system; you get at some of these other issues, it is possible that America can stay here and have the highest quality in the world, and it does not have to cost us as much. Thank you, Mr. Chairman.

Senator DASCHLE. Thank you, Senator. You have all made a very compelling case for the lack of equity in some of the proposals that have been made with regard to cuts again in the budgets, for good reason.

I understand why you have not been as forthcoming with ways in which to deal with the proliferation of costs that we have to face.

This year, the Health and Welfare budget of our country at the Federal level will be $585 billion. That is over one-third of the entire budget. And, as you all know, it is the fastest growing part of the budget.

So, we are stuck. On one hand, we do not want to do things that are being proposed because of the clear detrimental effect it will have on some of the varied people you represent.

On the other hand, we cannot go to the taxpayers and say our answer is to find more money to spend on health care. And so, we are really in a box, and we have got to find a way with which to say we can do more with less. And we have got to find ways with which to more equitably bring down the costs.

Just as a parting shot, I would be interested if you could give us your best insight as to how you do that. Put yourself in our position and give us your best thinking with regard to how it is we control costs if it is not the approach you have all criticized.

Dr. Eggers.

Dr. EGGERS. That is a large question for the problem that we presented, and, as I look at it, in our particular problems related to the anesthesia care team, it is a particular mode of practice that

is very good in rural areas, or in States with low populations. And, for the first time, Mr. Gray and I are sitting side-by-side agreeing on some things. We do not agree on everything, nor do our constituents. But we totally agree on the hope and desire to continue with the anesthesia care team mode.

We do not believe this is possible with these proposed cuts which would change the whole mode of practice that we are currently utilizing. And also, we totally agree regarding anesthesia average times.

Senator DASCHLE. But you acknowledge, do you not, that these cuts are not being proposed because anyone would argue that it improves care. I mean, they are being proposed—they are motivated in an effort to reduce cost.

And, so, obviously the question then becomes, how do we do both? How do we maintain the quality of care that the team approach provides?

And I am from South Dakota, a State that benefits from the team approach. But then the question is, if we are going to keep the team approach, how do we do it without spending more money?

Dr. EGGERS. Not easy to answer. We have to all do with less. I think that the capping makes it inappropriate for a physician to continue in this mode. The only way would be to increase the differences between the two payors, I guess, and make it feasible from that standpoint.

But there is not a simple answer to a very complicated question, because the quality is what we want to maintain. We have found this to be a successful, appropriate way to practice. We do not want to lose that. That is the main thing that we do not want to lose.

Senator DASCHLE. But I guess you would acknowledge that if we do nothing in the team approach, and in every other aspect of providing good health care, there is not going to be any prospect of controlling cost. Would you not acknowledge that?

Dr. EGGERS. It appears that way.

Senator DASCHLE. And so, that is the box we are in. Where does the money come from? Why is it that at the end of every year we have to put the dollar amount on the check? Why can we not do a better job prospectively of ensuring quality and providing the kind of care that we all want? That is what we are up against.

And I fully appreciate the detrimental impact that this is going to have, and it is one of the three or four reasons why I do not support this approach.

But I do think it is imperative that if we are not going to support this approach that we also recognize that we are responsible for coming up with an alternative that will work just as well.

Because the alternative to not doing that is to do nothing, which is to get us farther and farther into a situation that, frankly, is virtually out of control already.

Mr. Gray, do you have any advice you can give us?

Mr. GRAY. Well, one of the things that I think that the Federal system some day has to look at, and they have always been loathe to do that, is opening up more providers in the system.

And I know the insurance side of that argument is if you open more providers it ups the output, but I think part of the reason for that, if you look at it from opening up this system more, is that

you will make a more competitive system because competition does drive down costs—or it should, if it is done in the right way.

Senator DASCHLE. It does sometimes.

Mr. GRAY. It does sometimes.

Senator DASCHLE. I think I could argue that it does not always.

Mr. GRAY. But if you do not have any competition within the system, as there is now in the medical system in this country generally—other than in anesthesia, midwifery, obstetrics, and psychology which are the only places you have any competition at all—you continue to have one provider that has all the answers, and you will continue to have this problem.

Because you cap one area, and I guarantee you they will find a new procedure to outlay those funds for you.

Senator DASCHLE. So, you would argue—and I think I share this position—that greater roles for mid-level practitioners would help us reduce costs.

Mr. GRAY. I think so. And without a drop in quality of care.

Senator DASCHLE. I see we have a vote on, so I guess I am going to have to ask the other witnesses to be brief. But in what brief time I have, Ms. Parver or Ms. Foster, what advice would you have for us?

Ms. PARVER. Yes. I would just like to say, Senator Daschle, that studies have shown that home care, home medical equipment, after an episode in an institution is more cost-effective than just providing the care in an institutional setting, be it a hospital or nursing home.

And the provision of care in the home where people prefer to be, being that it is cost-effective, is something that is an approach that we would encourage.

The State of Maryland, for example, has a program which brings ventilator-dependent children home from the hospital. We know that the State has saved approximately $80,000 in 1 year alone just for one child whose case study we have been following.

So, I would encourage more access to home care; more access to provision of home medical equipment in the home.

Senator DASCHLE. Thank you. Ms. Foster?

Ms. FOSTER. Anticipating that you might ask this question, I would direct your attention to pages, I believe, 7 and 8 of our written testimony, which do provide an alternative that we believe will reduce expenditures and will allow you to cut Medicare payment rates for laboratory services.

Tomorrow I will deliver to your office additional materials which will amplify upon this proposal. It is the direct billing proposal which I was beginning to discuss when that ugly little red light went on during my oral presentation. I will give you as many details on this as you can stomach.

Senator DASCHLE. Very good. Well, I can stomach a good deal, I am sure. Listen, thank you all. We have enjoyed your testimony. We appreciate your waiting as long as you have to testify. And, with that, the hearing stands adjourned.

[Whereupon, the hearing was concluded at 6:05 p.m.]

ECONOMIC GROWTH AND THE PRESIDENT'S BUDGET PROPOSALS

WEDNESDAY, FEBRUARY 19, 1992

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:00 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Lloyd Bentsen (chairman of the committee) presiding.

Also present: Senators Danforth and Grassley.

OPENING STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS, CHAIRMAN, SENATE FINANCE COMMITTEE

The CHAIRMAN. If you will please cease conversation the hearing will get underway. Today we are meeting for the fourth time in an effort to craft a set of proposals to help pull this economy out of a recession, to put it back on the track toward growth if we are going to help our Nation become more competitive. And that has to be our goal. We need long-term solutions and not a short-term fix; and we sure need to act promptly.

The American people deserve no less and I think they showed that in the New Hampshire Presidential primary yesterday with their reaction to the President's not moving as quickly as they thought he should have on the economy.

Over the past few days this Committee has heard testimony from a broad spectrum of witnesses, testimony that will help us as we act on legislation. Secretary Brady, OMB Director Darman and Chairman Boskin of the Council of Economic Advisors appeared on the first day of hearings to give us the President's views. Next, economists and a range of private sector representatives—small businesses, manufacturing firms, high technology firms, the energy community, and the real estate industry—gave their perspectives on the President's budget and the measures that needed to accomplish our economic goals.

In addition, we have had written submissions from many more regarding all aspects of the President's budget. Yesterday the Committee heard testimony on the President's proposals for health, income security and social service programs within the Finance Committee's jurisdiction.

Today we are hearing from the elected officials, who in the very near future are going to be passing judgments on economic growth proposals.

Now we will turn to matters of particular concern to those of you present today and it will aid the Committee enormously to understand your concerns before we begin to mark up this bill.

For the first witness this morning we will have Senator Don Nickles, the U.S. Senator from the State of Oklahoma, and he is accompanied by Mr. Richard Zartler who is the pesident of the Grace Drilling Co. in Dallas, TX. We are pleased to have you both.

Senator Nickles?

STATEMENT OF HON. DON NICKLES, A U.S. SENATOR FROM OKLAHOMA, ACCOMPANIED BY RICHARD A. ZARTLER, PRESIDENT, GRACE DRILLING CO., DALLAS, TX

Senator NICKLES. Mr. Chairman, thank you very much. I appreciate your having this hearing and also your willingness to consider statements by myself and several others on some ideas I think will work towards enacting positive changes in the Tax Code that will help the economy.

Mr. Chairman, let me just say first and foremost, I have enjoyed working with you. I really hope that in Congress we will work together to formulate a bipartisan plan to pass something that will help the economy. I see a lot of different ideas being bandied about in Congress right now; and frankly, some of which have no chance of passage, that the President is not going to sign.

I hope that we will work on a tax bill that will help stimulate the economy, that frankly, Mr. Chairman, will correct some mistakes that were made in 1986 and 1990. I think Congress, while well intentioned, made some changes that were mistakes—mistakes such as passive loss dealing with real estate. I think we went too far. It hurt the real estate industry too much and as a result hurt banks and S&Ls. I think we can come together in a bipartisan fashion to make changes that can be agreed upon this year.

Mr. Chairman, what I wanted to state to you today is from the perspective of Don Nickles who is running a manufacturing plant in Ponca City, OK, that went through some very good years. I saw some tax changes that were very positive. Unfortunately, I saw some changes that were made in 1986 that were detrimental to a manufacturing company.

I would encourage this Committee to makes some changes, and again in a bipartisan fashion, dealing with investment tax allowance or investment tax credit. Something along the line the President has proposed or maybe something a little different. Maybe it would be an investment tax credit or maybe it would be accelerated depreciation and allow that accelerated depreciation to be deducted, not just added back as a credit against alternative minimum tax, which has really discouraged investments in plant and machinery and equipment.

I would certainly encourage the Committee to make changes on alternative minimum tax as it pertains to the oil and gas industry, for intangible drilling costs. Mr. Chairman, I think a lot of our colleagues are not aware—I know that you are well aware—of the terrible state right now that we have in the oil and gas industry, the fact that we have the lowest number of rigs running since the 1940's. Really, we have a depression in the drilling industry. So we need to make some changes.

One of the changes that was made in 1986 did a lot of damage. That was adding intangible drilling costs which are an out-of-pocket business expense, adding those as a preference item to alternative minimum tax. The net result being a 20-percent tax surcharge on expenses in drilling a well for a corporation. For an individual it's a 24 percent surcharge on expenses.

Mr. Chairman, with your business background and with mine, you are supposed to tax net income. You are not supposed to have tax surcharges on expenses. That is what is really wrong with the intangible drilling cost added as a preference item. It needs to be changed and I hope that this Committee will enact those changes this year.

I think that would probably do more to stimulate the domestic drilling industry than any other change. So I hope that that will be included.

Likewise, Mr. Chairman, I would really hope that percentage depletion would be taken off the preference list as well, and especially percentage depletion on stripper wells. In our State of Oklahoma we have about 71,000 stripper wells in the State. Those are wells that are averaging less than three barrels per day. Those are wells that are barely hanging on right now.

I think if we made this change—again, in 1986 in the Tax Code we added percentage depletion onto alternative minimum tax. You add those two things together with intangible drilling costs and we really did hurt the domestic oil and gas industry. I think if we would take both of those out we would give some support to an industry that is really going through some very, very difficult times.

Also, Mr. Chairman, when you get into the difficult question of how are we going to pay for it, I would say that those two changes are going to generate income. They are going to generate jobs. Because right now as I mentioned the domestic drilling industry is dying. If we only have 650 or 670 rigs running nationwide they are not producing very many jobs. So we need to stimulate more drilling, more activity that will create more jobs, that will create more taxes for the government.

So these are a couple of the changes that I think can and could and should be made, as well as other changes that would really help the economy—deducting interest on loans, credit for home buying—other things that we can do that we can pass. Mr. Chairman, I think that's awfully important. I am not really interested in coming up with a tax bill that, well this is a Republican tax bill and this is a Democrat's tax bill; and the Democrat's tax bill is basically a massive redistribution of wealth. The President is not going to sign that. The President is not going to sign a bill—where, we are going to rob Peter to pay Paul or buy votes and so on.

So I hope we avoid those kinds of class warfare, political warfare and that we will really take the elements that are mutually agreeable, ones that are acceptable to the Chairman and ones that we can pass in Congress, whether you are talking about passive losses, changes on alternative minimum tax, changes on allowing businesses to be able to deduct their equipment over a shorter period of time, changes that will help stimulate the economy in a positive way that will create jobs. That is really what Congress could and

should be doing. That is what can become law; and I hope that that is what we will enact this year.

Mr. Chairman, I have a more lengthy statement; and I would just insert it in the record.

The CHAIRMAN. We will take it in its entirety.

Senator NICKLES. Thank you very much, Mr. Chairman.

[The prepared statement of Senator Nickles appears in the appendix.]

The CHAIRMAN. Did you want Mr. Zartler to make a statement?

Senator NICKLES. Yes.

The CHAIRMAN. I would be pleased to hear from him.

Senator NICKLES. Go ahead.

STATEMENT OF RICHARD A. ZARTLER, PRESIDENT, GRACE DRILLING CO., DALLAS, TX

Mr. ZARTLER. Mr. Chairman, thank you. My comments will be brief.

I am president of Grace Drilling Co. in Dallas, TX. We are the largest drilling contractor in the United States. We operate in 18 States, including Alaska. I see first hand the collapse of our business.

We believe that the inclusion of intangible drilling and percentage depletion as preference items in the calculation of alternative minimum taxes unfairly penalizes a small independent oil man who historically have drilled 75 to 80 percent of the wells in this country. That penalty comes because they are not able to deduct what has been historically considered legitimate business expenses.

And since the enactment of these preference items in the alternative minimum tax calculations, exploratory drilling is down 38 percent. We have lost 200,000 jobs in the domestic oil and gas industry. That is 88 jobs every day. That decline continues today.

My firm laid off last year one out of every six employees. That was 374 people and it was everywhere from Fort Smith, AR, to Kenai, AK. Because our people basically work in small towns and are the sole bread winners, not only is it a single employee, it is 374 families that have been decimated. We are a local business. We provide local services. And our people have been hurt substantially.

Finally, oil and gas reserves. New drilling has found only 50 percent of our production. So we are rapidly depleting a very critical resource. That, as I see it, we are really decimating our business. We are hurting our people. The technological position that the United States drilling industry has had—for 100 years we have been the leader in the world—is clearly declining every single day.

Our children no longer seek petroleum engineering degrees or geology degrees. Our R&D budgets are being cut every single day. We are taking this business apart. We are not asking for special treatment; we are only asking for fair treatment. We would like to deduct those expenses that we have historically been able to deduct and we think we will be able to put our people back to work.

Thank you.

[The prepared statement of Dick Zartler appears in the appendix.]

Senator NICKLES. Mr. Chairman?

The CHAIRMAN. Yes.

Senator NICKLES. I would like to also submit a very brief report submitted by the University of Oklahoma, their observations on the impact of changes or actually restoring alternative minimum tax changes where we take out intangible drilling costs and percentage depletion. The conclusion of their statement notes that if we had more favorable alternative minimum tax treatment it would increase drilling 17 to 25 percent.

This is the report from the University of Oklahoma. I would like to submit that as well.

The CHAIRMAN. We would be delighted to have it.

Senator NICKLES. Mr. Chairman, thank you.

[The report appears in the appendix.]

The CHAIRMAN. Let me tell you what a problem it is.

Mr. ZARTLER. I'm sorry?

The CHAIRMAN. Let me tell you what our problem is. We, the Congress, are in a budget agreement with the Administration. I want very much to see that we keep the limits insofar as not busting the budget, not increasing the deficit. I feel very strongly about that. I think that is an imperative.

We have seen an enormous increase in the deficit. We have seen an enormous increase in the debt of this country and that has to be turned around.

On passive losses no one fought that more than I did in this Committee for fair treatment of investers. I was not the Chairman at that time. I said what you are going to do by retroactively imposing the passive loss provision is to drive away the limited partner who has no liability and sees his cash flow all of a sudden diminished, whether he is a banker, a lawyer, a doctor, whoever invested it in real estate shelter will drop it.

Then the investment reverts to the general partner. He cannot handle it; he goes broke. Then it goes to the S&L and they cannot cover the loss and as a result we have had serious financial problems in this country. But I lost that vote by one vote on retroactivity in this Committee. What I prophesied happened.

Now let me tell you the other part of the problem. We cannot have somebody make $1 million and pay no taxes. That destroys credibility in this tax system and people quit paying their taxes. You cannot have that. That is the reason for the alternative minimum tax.

In 1990, I led the fight to help bring about $2.5 billion more cuts to try to help the oil and gas industry which is in such serious trouble; and we won that fight in the conference. We fought for $4 billion in this Committee; $2.5 in that conference and we won it and the Administration supported it. This time it is not in the Administration's budget.

Regardless of the point about more people working—and I sure agree with that—but I have to look at what the budget estimate is by OMB and we have CBO. You know what all these acronyms means. I am so sorry. We have so many of them.

Mr. ZARTLER. I get the gist.

The CHAIRMAN. But anyway, that is where I am locked in. The estimate will be that that is a loser in the 5-year span and you have to make it up some place. It is very easy to be for the tax cuts. But if you are going to stay within the budget limitations,

how do you make it up? Where it is credited, by the Office of Management and Budget for the Administration or by the Congressional Budget Office for the Congress?

Those are the restrictions within which this Committee operates and which I am going to abide by.

People are not studying petroleum engineering anymore? You bet. You are right. Further dependence on foreign oil? Absolutely.

Three years ago I led the fight to try to put an import fee on it. The Administration fought me tooth and toe nail and we lost it. It was not just the Administration, others too, and divisions within the industry itself, strictly by the large companies opposing it. We are reaping now what has happened because we did not take those kinds of actions.

I understand your concern and I sure share it with you. I appreciate your comments on it.

Senator NICKLES. Mr. Chairman, thank you very much.

Mr. ZARTLER. Thank you.

The CHAIRMAN. Senator Boren, the senior Senator from the State of Oklahoma, a very influential, valued member of this Committee. We are delighted to have you.

OPENING STATEMENT OF HON. DAVID L. BOREN, A U.S. SENATOR FROM OKLAHOMA

Senator BOREN. Thank you very much, Mr. Chairman. I appreciate the opportunity to discuss with you two components of the comprehensive legislative program that I introduced several weeks ago, the Tax Fairness and Competitive Act.

Let me say in the beginning that I hope as our Committee begins deliberations that we will find a way to craft a bipartisan solution as we look at tax and economic policy. I think one of the worst messages we could send to the American people is that we are unable to put partisanship aside even in an election year to come up with a package that would have joint bipartisan support.

As I talk to my constituents, they make it very clear to me that they are most worried about what they view as petty partisan differences instead of Congress trying to work out something that can be enacted swiftly and signed into law swiftly by the President swiftly.

So it is my hope that as our Committee gets together to work on a final package that we will not be intent on scoring points one way or the other, scoring points by sending the President a bill we think he might veto. I would hope that the other side of the aisle would not be interested in trying to score political points by making unreasonable demands that they know are not acceptable to our side of the aisle.

I hope instead we can once and for all prove the cynics wrong and show that we can get together on a bipartisan package. That will certainly be my approach as I act as a member of our Committee and I hope it will be the approach of the entire membership of the Committee even though election year politics will tempt us to move in other directions.

We owe it to the American people to consider the good of the country instead of the good of any political party or the good of any individual in the political process. That is what the American peo-

ple want and I hope that we can prove that we are capable of it in the United States Senate. If there is anything we can do to restore the integrity of this institution and confidence of the people in this institution, it is to put aside this kind of foolish partisanship at a time when our country is in trouble and our people are suffering.

Today I want to emphasize two provisions of the Act that I believe should be included in any economic growth proposal that the Committee adopts. I think it is important that we be guided by one overriding principal as we discuss draft legislation to stimulate the economy. While suggestions for a quick fix may be superficially attractive, we must not lose sight of the important long-term objectives that will allow us to compete effectively in the international marketplace. In the long run we can ensure real economic growth and permanent economic health by using the tax system to encourage productivity in the workplace and to decrease the cost of capital.

With this objective in mind, I strongly suggest that the Committee adopt legislation that would provide middle income taxpayers with relief, but would not be counterproductive to our long-range economic interests. Proposals that result in an additional income of approximately $1 a day do not meet that requirement. Cosmetically they may appear to be helpful to the middle class. They are not really helpful in the long run. They do not create jobs; they do not create work opportunities for those who are caught in the middle income squeeze.

Americans in the long run are more interested in jobs and economic opportunity and economic growth. We have certainly seen that emphasized by candidates in both political parties during the New Hampshire primary. And I think if voters were trying to say anything in New Hampshire, it was that. We do not want a cosmetic 90 cents a day tax cut. We want jobs. We want economic growth. We want real substance. We want to be approached as intelligent Americans who can understand economic reality.

Senator Grassley and I have suggested a different kind of relief for middle income citizens, a deduction or a tax credit for interest on loans used to finance higher education. One of the most pressing financial burdens on middle-income Americans is the cost of financing their children's higher education.

As I have often discussed with members of this Committee, higher education expenses are typical of the double bind in which many of these Americans find themselves. Students of limited means can qualify for scholarships and grants; the children of the wealthy have no worry when it comes to paying for college. Middle income parents, however, find themselves facing an average cost for college education of $6,000 to $22,000 a year, with most of their net worth tied up in their homes which usually this does not exceed $60,000 in total net worth. They have no choice but to take out substantial loans.

This is more than a question of middle income tax relief, Mr. Chairman. The long-term economic health of this Nation depends on a skilled and educated work force. The Federal Government has an obligation to do what it can within the limits of our resources

to make higher education affordable for the largest segment of our economy.

The legislation that Senator Grassley and I propose has two advantages over other student loan interest proposals being discussed. First, it allows the taxpayer a choice between a deduction and a tax credit, thereby helping those taxpayers who do not itemize. Second, it is limited to interest paid during the first 4 months of repayment. It is a less expensive proposal.

I know there are other proposals to adopt additional funding mechanisms that would create a new pool of money to be used to fund higher education, I am not opposed to those proposals, some provide that it be paid back at 10 percent of income the first several years after college. These are good proposals, but they are not a substitute for the interest deduction which will still be the primary option for most middle income taxpayers.

Mr. Chairman, I would request that written statements from higher educational organizations and groups, including the American Council on Education, the umbrella supporting organization of all higher education, the American Association of University Professors, the administrations of universities chosen at random, like the University of Texas, Baylor University and others, be inserted in the record at this point.

Senator BOREN. The second provision I wish to highlight today is one that looks at long-term economic policy. I will do this briefly because I see the yellow light already on.

The CHAIRMAN. No, do not worry about that, Senator.

Senator BOREN. We in Congress have only recently focused on the unintended economic effects of the alternative minimum tax. The AMT was designed to guarantee that profitable companies would not avoid paying any taxes. And I think that is what most members of Congress think that they passed when they passed the minimum tax. They think they closed the loophole to make sure that companies having immense profits were to pay at least some tax and not avoid tax altogether.

We did not intend it to result in a higher marginal tax rate on companies that had lower profits because of a recession but continued to make substantial capital expenditures. Nor did we intend to penalize the ordinary and necessary business expenses of an important industry, the independent oil and gas industry. Yet both of these unintended effects appear to be occurring.

We have companies that have no profit at all or very substantial profits. Because they are doing exactly what we want them to do—make investments, look to the future, build their technological base, buy new equipment, increase their productivity—we then turn around and penalize them for making those investments in the Tax Code.

This is not a question of plugging a loophole. It is a question now of penalizing people for doing what this country urgently needs—make investments to improve productivity and competitiveness in the future.

My proposal addresses these concerns. First, it would allow a company that has been paying the alternative minimum tax for three of the past 5 years to apply its accumulated AMT credits against its AMT liability. The AMT credit was originally designed

to be a pre-payment of tax that could be used to offset income once the company started paying regular corporate taxes again.

Congress expected that a company would be an AMT player for only a few years, so that the AMT credit would have value when it was available for use. That expectation has not proved to be accurate. Since 1986 a substantial number of companies have been paying the AMT for years, and they have no realistic hope of emerging from that position in the near future.

Unless they can use AMT credits that they have accumulated to offset their AMT liability, these credits will be of little value to them.

Second, our independent oil and gas industry has been devastated, as Senator Nickles has just said, by the AMT. The independent oil and gas industry drills 85 percent of the wells in this country; it is responsible for 60 percent of our natural gas, 40 percent of our oil. Put simply, this is a critical industry. Its importance should have been brought home to us dramatically a year ago when this country went to war in the Persian Gulf, in part to secure vital sources of oil.

Our domestic industry is facing a crisis. The rig count, which is this industry's measure of drilling activity, reached its lowest level in history in January. How long are we going to wait to do something? How many more times will we be forced to put young Americans at risk before we encourage energy independence?

I know the Chairman knows this full well. I just heard him say as I came into the room that he has led a fight for this effort in this Committee, and time and time again we have struggled to convince our colleagues. The Chairman has attempted to educate our colleagues of the need to do something. Mr. Chairman, it is my hope that this year we can follow your lead and be successful.

My proposal, which has also been introduced by Senator Breaux, is to eliminate two necessary business expenses for independent producers—intangible drillings costs and percentage depletion as a tax preference under the AMT. This way the independents would be treated like every other business which can deduct its ordinary expenses under either the regular or the alternative system.

Let me point out also that our bill would not allow any company to avoid paying tax altogether because we would not allow for a full 100 percent offset of AMT credits against AMT liabilities. There would be a limitation so that at least some amount of tax would be paid and no one would escape taxation completely.

We face a challenge in the next few weeks. The country is suffering from a short-term economic downturn. That is a definite, serious problem for us. We are concerned also about the longer term. And I think that is the most serious concern, being able to compete in the world marketplace in the long run.

Even if we solve the problems in the next few months, what is really worrying Americans fundamentally is whether their children and their grandchildren are going to have the same quality of life, the same economic opportunities that they have had. That is why, Mr. President—it has a nice ring to it——[Laughter.]

Mr. Chairman, I would urge that we put politics aside. The members of this Committee understand economics. We know it makes sense. Let us talk sense to the American people. Let us act upon

what we know is right. Let us not be tempted into the quick fix. Let us not be tempted into scoring partisan political points. Let us write in this Committee the best economic package to improve the long-term competitive position of the United States.

Then we can look at ourselves at the end of our deliberate process and we can say to ourselves: We have met our obligation to the American people and to the next generation. We have done what Senators ought to do. We will have acted to restore some modicum of confidence and trust of the American people in this institution again. I believe the membership of our Committee, the leadership of our Committee, is uniquely positioned and has the unique knowledge and experience for that kind of undertaking.

The CHAIRMAN. Senator, I am most appreciative of your statement. We share many of the same concerns and have for a long time in fighting for some of these objectives.

One of the problems you run into with an alternative minimum tax, well intentioned and aimed at problems like this are, as I recall you had over 100 companies, big companies, reporting enormous profits to their stockholders on their annual statements and paying no taxes.

Senator BOREN. Right.

The CHAIRMAN. I can remember one of the very largest companies in this country 6 straight years made over hundreds of millions of dollars, every year, paid no taxes, yet reporting their stockholders those kind of earnings. That is what it was aimed at.

But there have been some problems unanticipated and some things have to be corrected on really capital intensive companies and I understand that.

Certainly the oil industry is in the pits. Nobody wants to study petroleum engineering. More dependence on foreign oil. I sure share those concerns. International competitiveness, most of the studies show that what we really have to have is an educated work force in this country to be internationally competitive.

So I am certainly sympathetic to those things that help promote education. I think what you propose this morning has a lot of merit to it. To the extent we can work these into the budget, and not bust the budget, I am going to be supportive.

Senator BOREN. I appreciate your comments very much, Mr. Chairman; and I understand the problem you have to work with. Unfortunately, we operate under rules that do not always allow our Committee to have the resources necessary to do what we would want to do from the point of view of sound tax policy. We are forced to come up with funds within the Code very often, and this makes the task very difficult. So these artificial constraints, I understand, make your task a lot more difficult. I am certainly sensitive to that.

But I certainly share your hope that we can write sound tax policy that will really become helpmate to economic policy in this country. I think sometimes because of these constraints we have had to divorce our tax decisions from the centrality of economic policy. I know that is something you have pointed out many, many times; and I hope this year perhaps we can find a way to bring it more in line with what economic policy decisions would dictate.

The CHAIRMAN. Thank you very much, Senator.

Senator BOREN. Thank you.

The CHAIRMAN. Well, we have had a Senator here waiting very patiently from the beginning of the hearings. We have taken the Senators in the order in which they asked to appear. We are delighted to have Senator Harry Reid, a U.S. Senator from the State of Nevada.

STATEMENT OF HON. HARRY REID, A U.S. SENATOR FROM NEVADA

Senator REID. Thank you, Mr. Chairman. I have learned while listening to my colleagues testify about the problems they see with the tax structure of this country.

I have, I think, two relatively small matters that also address the fairness issue within the Tax Code. I would ask permission of the Chairman that my full statement be made part of the record.

The CHAIRMAN. That will be done.

[The prepared statement of Senator Reid appears in the appendix.]

Senator REID. Mr. Chairman, I want to talk about two issues. One is a matter about which I have appeared before this Committee on a previous occasion called a source tax. In effect what happens is that people work in one State and retire in another State. Low and behold, they find that not only is the pension they receive from that other State, or other business in that State, taxed but they may also find that all of their income is taxed. And as a result it makes the lives of people on fixed income very difficult. The State that they live in takes care of the health care delivery system. Mr. Chairman, it takes care of all the law enforcement. It takes care of all the parks—everything in the State where they live, but they in effect are paying taxes to the other State which provides none of these resources. If there were ever a case of taxation without representation, this is it.

In addition, the State where the retiree currently resides also may be losing revenue. Many States offer a tax credit when their residents pay taxes to another State. While the State of residence provides the services as well as the right to vote, the State where the taxes are being paid provides basically nothing.

I think it is important to stop this tax which is so unfair. In the House of Representatives we have about 180 sponsors of this legislation. In the Senate, Mr. Chairman, we have 24 co-sponsors of this legislation. Without going into more detail because I have testified before this Committee on a previous occasion on this subject, it would be the fair thing to do. The Federal Government loses no money. It is a total wash.

The second bill I would like to bring to the Committee's attention is S. 1398, a bill which would restore the exclusion from gross income for contributions in the aid of construction or CIAC. It has been estimated that up to $2,000 could be saved on the cost of a home if utilities did not have to treat these contributions as income. In fact, several of the Committee members are co-sponsors of this bill. We have 24 co-sponsors in the Senate of this legislation.

When a facility, such as a house, school or government building is being constructed, builders extend gas and water mains and electrical lines into their developments. They then turn this property

over to the utilities without charge or they pay the utilities to install the lines themselves.

Prior to the Tax Reform Act of 1986 these contributions were not taxable as income. The CIAC was excluded from the utilities rate base for rate making purposes. Further, since the utility was precluded from claiming either tax depreciation or investment tax credit with respect to the property, the CIAC had no effect on the utilities tax liability in the current or subsequent years.

Therefore, the Federal income tax treatment of CIAC had no affect on rates charged consumers. The 1986 law changed this by subjecting CIAC to tax as gross income. The intent was to place part of the new corporate tax burden on utilities. In fact, what has happened is the utility passes the tax on to consumers which results in a detrimental affect on the utility, on the environment and the cost of housing.

Mr. Chairman, as a result of the change to CIAC in 1986 these contributors must now make a substantially larger contribution than has been made in the past so the utility is reimbursed for the additional tax burden. The contributor must also reimburse the utility for the tax on the tax, or "gross up," which may be as much as 70 percent above the original cost of the contribution.

Let me say that this Committee favorably approved this legislation as related to water on a previous occasion. But because of some of the agreements made with the Administration that there could be nothing that changed the revenue patterns it was dropped from the Tax Bill in 1988.

It would be fair to adopt this legislation this. The cost to the Government, if it were related just to water, Mr. Chairman, would be $120 million over 5 years. If all the other utilities were included it would be $600 million over 5 years.

Again, I appreciate the permission of the Chairman to have my full statement submitted to the record and look forward to working with you on these two relatively small matters.

The CHAIRMAN. Senator, thank you very much. I appreciate your testimony. I recall your testimony before. We will be delighted to consider it. Thank you.

I will not hold you because I would like to let Senator Robb testify before this vote if we can.

We are delighted to have you, Senator.

STATEMENT OF HON. CHARLES S. ROBB, A U.S. SENATOR FROM VIRGINIA

Senator ROBB. Thank you, Mr. Chairman. I appreciate the opportunity. In view of the fact that a vote is in progress at this point and I am scheduled to preside over the Senate at the conclusion of the vote, I would request permission from the Chairman to simply insert a statement for the record. The statement that I would insert is very similar to one I gave on the floor of the Senate about 2 weeks ago when a sense of the Senate resolution which I introduced and which was accepted by the managers on the current energy bill requested this Committee and its Chairman to look at a proposal that would in effect shift the place that taxes are collected from the income tax to the gasoline pump.

The proposal as outlined would be revenue neutral. It would have the advantage at least in the eyes of those who have provided advice and counsel to me of both encouraging energy independence, which is certainly one of the focal points of much of the discussion before this Committee, as well as benefiting the environment. It would join the environmental and the national security communities at least in terms of both moving in the same direction.

I recognize that it is the kind of proposal that would require some very careful study by this Committee. I have included in the sense of the Senate resolution and some backup material some indications of preliminary judgments as to what the effect might be, but I think a thorough objective examination of the proposal or something like it by this Committee would go a long way towards giving us some indication whether this is a reasonable way to approach both the question of energy independence as well as the question of providing some environmental protection that would be desirable.

With that, Mr. Chairman, I would simply ask that I be permitted to present a statement for the record; and I would be pleased to work with the Chairman and with the Committee at some future time as this proposal is studied.

[The prepared statement of Senator Robb appears in the appendix.]

The CHAIRMAN. Senator, that is a very interesting proposal and we would be delighted to consider it. This Senator went to the conference the last time on the budget with a 9.5 cent gasoline tax, which meant that we would be using that to a higher degree than some of the other tax revenue measures that finally went in the bill.

We were only able to retain 5 cents of that in the conference with the House.

Senator ROBB. Given the geographical roots of the distinguished Chairman of this Committee I think that would be regarded as a brave proposal and I commend this approach to the Chairman, at least for an objective consideration by the Committee.

The CHAIRMAN. Senator, coming from Texas and a driving State, in 1973 at the time of long lines at the gas pump, I went into the Democratic Policy Committee and proposed a 25 cent tax to do away with rationing. I can recall the Senator from Rhode Island, John Pastore, said, "No, no. Not by a damn sight." And when I said, "Why?" He said, "I passed a 1 cent gasoline tax as Governor and they named it after me." [Laughter.]

Senator, we had better go vote. Thank you.

Senator ROBB. Thank you.

The CHAIRMAN. We stand in recess for about 20 minutes.

AFTER RECESS

The CHAIRMAN. If you will cease conversation, the hearing will resume.

We are pleased to have Mr. Marshall Plummer, who is the vice president of the Navajo Nation.

Mr. Plummer?

STATEMENT OF MARSHALL PLUMMER, VICE PRESIDENT, NAVAJO NATION, WINDOW ROCK, AZ

Mr. PLUMMER. Thank you very much, Mr. Chairman, Senator Bentsen. First of all I want to send greetings from President Peterson Zah. We had an opportunity to greet you 4 years ago in Shiprock if you remember.

The CHAIRMAN. That I remember very well. It was a pleasant occasion.

Mr. PLUMMER. You saw our conditions and, of course, our people and our lands. President Peterson Zah sends his greetings and wishes you well.

The CHAIRMAN. Thank you.

Mr. PLUMMER. My name is Marshall Plummer. I am the elected vice president of the Navajo Nation, the country's largest Indian tribe. I testify today in support of the Navajo Nation's proposal for Federal tax incentives to help address the high levels of unemployment and poverty that exists in Indian country throughout the Nation.

You know, it is amazing to hear testimony this morning and, of course, testimony throughout the nation that because of the downturn and the economy, people are beginning to hurt and to scream help. I am glad that that is happening because in Indian country we have been there all this time. It is for that reason that I asked that I testify before this Committee.

Mr. Zah presently is in Laughlin, Nevada meeting with Secretary Manual Lujan on water rights issues which is also very central to the Indian people. But we also feel equally important raising the issue that we present to you today.

I also want to express my appreciation to our distinguished Senator from Arizona, Senator DeConcini; and I want to thank him for his efforts that led to this opportunity to testify. I want to acknowledge and thank Chairman Daniel Inouye, Senator John McCain and other members of the Select Committee on Indian Affairs, including Senator Daschle, who also sits on this Committee.

Our tax incentive proposals draw heavily from past bills from the Senate Select Committee on Indian Affairs that have enjoyed support from both sides of the aisle. I come before this Committee to an attempt to convey the following message, that while there are many Americans who are hurting during these economic hard times, no single segment of our society is hurting worse than the American Indian.

The conditions of poverty that persists throughout Indian country are unspeakable and the levels of unemployment are staggering. As Chairman Inouye reported during his committee 1989 hearings on Indian Economic Development, the unemployment rate on the majority of Indian reservations is simply incomprehensible to the average American.

During the so-called Great Depression in the 1930's, unemployment averaged 25 to 30 percent. In 1989, the average rate in Indian country is 52 percent.

Just last July, Chairman Inouye updated these statistics when he testified before the House Ways and Means Committee about the alarming rate of unemployment in Indian country that ranged from an average of 56 to a high of 97 percent. The result here,

within the borders of the United States of America, is that most reservation Indians live under conditions far worse than exists in many of the Third World countries to which our government provides substantial foreign aid.

Indians lack many of the items that other Americans take for granted. Meaningful action by the Congress to attract investment and jobs to Indian country must also address basic questions of human dignity.

New approaches are urgently needed. An appropriate new approach is through Federal fiscal policy. In particular, Navajos urge that Congress adopt two Federal tax incentives that can help induce private sector investors to consider the potential for job-creating opportunities in Indian country.

First, the Navajo Nation proposes an investment tax credit targeted to Indian country. This so-called "Indian reservation credit" is geared specifically to reservations where Indian unemployment levels are high—the credit being limited in its applicability to reservations having an unemployment rate exceeding the national average by at least 300 percent.

The Indian reservation credit would offer a higher percentage credit for investment in Indian country than would otherwise be available under a nationwide investment tax credit. This differential is absolutely essential in order to help mitigate unique problems endemic to investing in Indian country—particularly the lack of infrastructure—which are not commonly shared by other depressed areas. Without such a differential, an investment tax credit—or any other tax incentive for that matter—would essentially be useless for reservation economic development. This is so because Indian country, both historically and at the present time, does not compete on the level playing field with even the most economically distressed non-Indian areas, due to "double taxation" by the States, infrastructure deficiencies and related problems.

Second, the Navajo Nation proposes an Indian employment credit aimed at increasing employment of Indians on reservations. An added incentive, a significantly higher credit, would be available to reservation employers having a workforce with at least 85 percent Indians. The credit focuses on job creation.

These complementary credits could be available directly to private sector employment and do not entail the establishment of a new governmental bureaucracy. Even more importantly, these programs only cost the Federal Government if they work. In that event, increased Federal revenues from increased employment, along with the anticipated decrease in public assistance payments, should render these proposals, at worst, revenue neutral.

The Navajo Nation recognizes the extraordinarily difficult task facing this Committee. On the other hand, I respectfully ask the Committee to recognize the seriousness of the unemployment in Indian country, and the urgency with which it must be addressed.

This year's tax bill provides Congress a unique and timely opportunity to move along a different path to promote Indian country economic development. That path—Federal tax incentives—lies within this Committee's jurisdiction. In this, the congressionally-designated "Year of the American Indian," I urge the Committee to incorporate within its revenue package these modest, but extremely

important, tax incentives, so that American Indians are not once again left behind or left out altogether.

As President Zah has stated: "Helping American Indians to help themselves is neither a Democratic nor a Republican issue; it is not a conservative policy or a liberal policy; it is not even a 'special interest' issue. Rather, it is a 'human' issue that must, and deserves to be, addressed from a national perspective on a bipartisan basis . . ."

The CHAIRMAN. Mr. Plummer, if you would summarize. We have a long list of witnesses this morning and we would like to ask you some questions.

Mr. PLUMMER. ". . . and with a real sense of urgency warranted by the deplorable conditions existing in Indian country—conditions which truly are a national disgrace."

I thank the Committee for its consideration and I strongly urge the Committee to adopt our proposal. These incentives will help level the playing field by providing tribal governments and Indian country business planners with additional tools to compete for the private sector investment and jobs that are so critical to the well-being of our people.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Plummer appears in the appendix.]

The CHAIRMAN. Mr. Plummer, tell me, did you meet with other Indian nations in trying to develop a consensus? Does this represent a consensus of proposals, considering the enormous hardships and the high unemployment that we are seeing in the Indian nations?

Mr. PLUMMER. Yes, sir, we have. We have just gotten the support of the National Congress on American Indians and their testimony also, I understand, will be submitted to this Committee.

The CHAIRMAN. Good.

Now with the problems we have in short-term concerns and long-term solutions we are working towards, and the constraints of the budget, if you had to pick one of those which would you choose as the highest priority of those recommendations you have made?

Mr. PLUMMER. Of the two recommendations that I have made?

The CHAIRMAN. Yes.

Mr. PLUMMER. The jobs credit.

The CHAIRMAN. The jobs credit?

Mr. PLUMMER. Yes.

The CHAIRMAN. All right.

Senator Danforth?

Senator DANFORTH. I have no questions.

The CHAIRMAN. Senator Grassley?

Senator GRASSLEY. I have no questions either, Mr. Chairman.

Mr. PLUMMER. Mr. Chairman, if I may?

The CHAIRMAN. Yes, sir.

Mr. PLUMMER. I also want to provide the Committee a study, an analysis, that was done by the National Indian Policy Center here at George Washington University here in Washington.

The CHAIRMAN. That will be taken in its entirety for the record.

[The study appears in the appendix.]

Mr. PLUMMER. Thank you.

The CHAIRMAN. Thank you very much for your testimony.

In the order of appearances, Senator Lautenberg, you were next.

STATEMENT OF HON. FRANK R. LAUTENBERG, A U.S. SENATOR FROM NEW JERSEY

Senator LAUTENBERG. Thank you very much, Mr. Chairman. I appreciate the fact that I have been able to hold my place and do my other business at the same time. Thank you very much, members of the Committee and Mr. Chairman, for the opportunity to testify today.

Mr. Chairman, as you know all too well, our Nation is in an economic crisis. Almost 9 million people are unemployed, and actively working for work. Of that number over 1.6 million have been jobless for more than 6 months. Meanwhile, those with jobs increasingly are looking over their own shoulder, never knowing when the axe may fall.

Mr. Chairman, nobody in this Congress has done more than you to address the problem of unemployment, and to improve the economic health of our country. You deserve enormous credit for your leadership in securing the extension of unemployment compensation benefits. You also deserve the thanks of all Americans for your work to increase savings through the Super IRA bill, which I have co-sponsored, and for your efforts to address the unfair tax burden on the middle class.

The CHAIRMAN. Thank you.

Senator LAUTENBERG. I know I do not have to tell you about the severe consequences of unemployment, for the jobless themselves and for the nation as a whole. Studies indicate that unemployed people have more family and medical problems, they commit more crimes, and they have higher rates of suicide.

Compounding matters, the unemployed face a catch-22—the longer they are out of work, the less attractive they become to prospective employers. It is a vicious cycle that is very hard to escape.

Mr. Chairman, the long-term unemployed need a helping hand to break out of that cycle. I, with Senators Riegle and Boren, have introduced legislation, S. 2220, designed to provide that helping hand. The bill is simple. It builds on a well-established, existing program, the targeted jobs tax credit.

Under current law, the TJTC is available to employers who hire from among nine targeted groups. These include economically disadvantaged youth, Vietnam era veterans, ex-convicts, vocational rehabilitation participants, AFDC recipients, and others.

The credit generally is calculated by taking 40 percent of the first $6,000 of qualifying first-year wages. Our legislation includes the long-term unemployed as a new targeted group for a period of 1 year. Under the proposal, employers who hire people who have been receiving unemployment compensation for at least 6 months will get the same benefits as those who hire ex-convicts or welfare recipients.

We also suggest a few special rules that would apply in the case of the long-term unemployed, such as establishing a wage cap. That would limit costs and ensure that taxpayers are not subsidizing the hiring of highly paid executives, people who have their own financial reserves.

Mr. Chairman, encouraging employment of the long-term unemployed is a matter of basic compassion. But it is also good economic and social policy. The long-term unemployed might represent what might be considered wasted human capital, resources that ought to be contributing to economic growth but are not.

Putting these people back to work and increasing their spending power should help stimulate the economy to the benefit of all Americans. Moreover, the long-term unemployed impose real costs on working Americans. When the unemployed stop paying taxes those in the work force have to make up the differences. And as joblessness increases, working Americans also bear greater burdens in paying for AFDC, food stamps and other social support programs.

In fact, according to CBO, for every 1 percent increase in unemployment beginning this January, the fiscal 1993 deficit will be increased by $50 billion.

Of course, beyond any economic benefits, reducing long-term unemployment should reduce the many social problems associated with long-term joblessness. As I suggested earlier, these problems range from increased demands on medical institutions to spousal and child abuse and other violent crimes.

This is not, Mr. Chairman, a cure-all for the problem of long-term unemployment. However, it does have some significant advantages. First, it can produce results quickly. It is simple. It is based on an established program. It does not require a lot of planning or new regulations and it can be understood by beneficiaries and businesses without a great deal of education and assistance.

Secondly, the bill would not require the creation of an enlarged government bureaucracy. That means greater efficiency and lower costs to taxpayers. It also ensures that we are not going to be stuck with an entrenched government structure of limited usefulness once the economy turns around.

Thirdly, the bill is well targeted. It helps those who have tried to help themselves. By limiting the legislation to those who have been receiving unemployment compensation we assure that those who are assisted are persons who were laid off against their will and have been actively seeking employment.

Fourth, the bill proposes a temporary solution to deal with what we all expect, what we all hope, will be a temporary problem. It will not create a permanent drain on the Federal Treasury. In fact, by pulling the long-term unemployed into the labor force, the legislation may well generate additional revenues for Federal, State and local governments well into the future.

And last, fifth, the bill proposes to reduce long-term unemployment directly. We have heard many proposals recently that would encourage people to do various things and give special breaks to a variety of groups. Proponents generally argue that each break will trigger a chain of events that eventually results in reduced unemployment.

In many cases that may be true. But if our real goal is to reduce long-term unemployment why not address the problem head on? The more direct our approach, the more confident we can be that it will work and work quickly.

And finally, I am hopeful that this proposal can avoid the intense partisan wrangling that has frustrated progress on so many economically related issues. The TJTC is supported by President Bush and enjoys strong bipartisan support in both Houses of Congress.

Before I close, Mr. Chairman, I want to mention another bill that I introduced with Senator Herb Kohl and several other co-sponsors, S. 693, that would allow unemployed individuals to make penalty-free withdrawals from their IRA's and other retirement plans. I testified about that before you last July and I will not repeat what I said then.

But while reducing long-term unemployment may be a higher priority, I hope that the Committee will take a look at that proposal as well, which would help the unemployed make ends meet while they look for work.

I thank you once again, Mr. Chairman, for your leadership, and for the opportunity to appear before you today. I appreciate it and I would be happy if there are any questions to try to answer them.

[The prepared statement of Senator Lautenberg appears in the appendix.]

The CHAIRMAN. Senator Lautenberg, I am very sympathetic to what you are proposing. Back in the 1970's I originated a broader version of a jobs credit which then evolved into the targeted jobs credit. So I am very supportive of it.

As a side comment, I was flying back from Mexico last weekend and all of a sudden I smelled cigarette smoke. I wondered where was Senator Lautenberg. I could not help but think what you have done to make it more comfortable to fly in this country. I am sorry it does not extend beyond the continent limits of the United States.

Senator LAUTENBERG. Can we attach that to a trade agreement, Mr. Chairman? [Laughter.]

The CHAIRMAN. That is a thought.

But I am delighted to have your proposal. It is one of those things that has an immediate impact when we are talking about high unemployment.

I defer to Senator Danforth.

Senator DANFORTH. Mr. Chairman, I have no questions.

The CHAIRMAN. Senator Grassley?

Senator GRASSLEY. I have no questions, Mr. Chairman.

The CHAIRMAN. Thank you very much for your presentation.

Senator LAUTENBERG. Thanks very much, Mr. Chairman and Committee members.

The CHAIRMAN. Thank you.

Senator Bumpers, we are very pleased to have you. I am looking forward to hearing your testimony.

STATEMENT OF HON. DALE BUMPERS, A U.S. SENATOR FROM ARKANSAS

Senator BUMPERS. Thank you very much, Mr. Chairman. On days like this I sure wish I were Chairman of the Finance Committee. I know you are having a wonderful time today.

I will be very brief, Mr. Chairman.

The CHAIRMAN. I will ask you not to elaborate on that. Thank you.

Senator BUMPERS. I think that most of the members of this Committee who are seated here are fairly familiar with my enterprise capital formation bill. I have been working on it for 5 years. The present bill, S. 1932, took over 1 year in the drafting with some seven of the biggest law firms in town helping out. We have done everything in the world to close every possible abuse or loophole.

But briefly, just for the record, Mr. Chairman, the incentive works like this. There are two categories—one is called "seed capital" and the other is called "venture capital." We separate those simply in the nomenclature just for identification purposes because they are treated a little differently.

Let me tell you about my bill and then I will tell you what the Ways and Means Committee did and how it differs very slightly from my bill. They have adopted my bill almost intact.

Number one, for investors who buy the stock of a small business which is either expanding or starting up a new business and which has paid in capital of $5 million or less, and who hang onto that investment for 5 years, they can exclude half of their gain from tax.

Illustration, you invest $1 million; 5 years from now your investment is worth $5 million. You have a $4 million gain. You exclude $2 million from taxation. The effective tax rate then becomes 14 percent.

Incidentally, one other feature of the so-called "seed capital" provision is, if you wish to hang onto the stock longer than 5 years you get an additional 10 percent exclusion for each year thereafter. So that at the end of 10 years you would pay no tax on the gain.

The second portion of the bill is for investments in the stock of a corporation with businesses between $5 million and $100 million in paid-in capital. That is the "venture capital" part of the bill. You can exclude half of the gain if you hold onto your investment for 5 years. But you cannot get the additional 10 percent for each year after 5 years. That is the only difference in the two incentives.

Now, Mr. Chairman, this is a bipartisan bill. We now have 47 co-sponsors—12 Republicans and 35 Democrats.

The bill allows corporations as well as individuals to invest. It is imminently bipartisan and I think is one of the greatest incentives for small business I have ever seen.

It will cost $900 million over the next 5 years. Do I have a way to pay for it yet? No. But that did not seem to bother the President in his State of the Union Address either. So we will find the $900 million if we can get this Committee and the Senate to go along with it.

The CHAIRMAN. As you say, it is one of the fun things of being the Chairman of the Finance Committee, finding out how you might pay for the tax incentives.

Senator BUMPERS. Finding out how you are going to pay for all these goodies.

The CHAIRMAN. Yes.

Senator BUMPERS. Well, Mr. Chairman, I could elaborate at length but that is the basic outline of the bill. It has tremendous bipartisan support.

What the Ways and Means Committee did, they applied it only to individual investors. Now I think that anybody who wants to invest ought to be allowed to. The idea of the whole bill is to get peo-

ple to invest in risky undertakings. This company is not bereft of ideas; it is bereft of capital for those ideas.

What I am trying to do is twofold. Number one, encourage people to do exactly what capital gains are supposed to encourage people to do and that is to take risk. The second thing I am trying to do is to provide capital for people who have good ideas and no money.

Now $100 million in Charleston, Arkansas is not a small business, just like it isn't in Nogalas or El Paso or any place else. But the biotech industry, who has been extremely supportive of this whole concept, tells me biotech startups are very expensive. That is one place where we are still extremely competitive with the Japanese and I made the threshold $100 million because we do want to encourage biotech startups.

One other thing, Mr. Chairman—two points—if the President's 15.4 percent rate for a 3-year holding period passes this bill becomes a nullity. Nobody is going to take a risk and hold an investment for 5 years for a 14 percent rate when they can take no risk to speak of and get a 15.4 percent rate and cash in at the end of 3 years.

The other thing is—and this is a little off what I came here to talk about—I hope, I divinely hope, that this Committee will not adopt the Ways and Means Committee's proposal on indexing. That is going to be double-dexing as we already indexed the Tax Code. It is going to be an effective double dipping if we add indexing just to the capital gains rate as I understand what they did.

The other thing is, I think it would be patently unfair to give a middle class tax cut for 1 or 2 years, take that off, and then leave the indexing intact. Now that is gratuitous. It did not cost a single penny extra. Not what I came here to testify about.

The CHAIRMAN. Thank you, Senator.

I am very enthusiastic about your proposal. I think you have shown some creative thinking that fits our targets.

I have one concern. You are going to have a lot of clever lawyers working, trying to see what they can do to qualify their clients for it. What about a situation where you have a very major corporation who wants to set up a subsidiary and puts it out under $100 million to try to take advantage of this?

Senator BUMPERS. Prohibited under the bill, absolutely prohibited if the corporation files a consolidated return with the subsidiary.

I don't care if IBM wants to invest in XYZ Corporation that is starting out in the cookie business in Arkansas. That is their prerogative. But they cannot own 80 percent more of its stock, which is the standard for consolidated returns. I mean they can invest in it, but it cannot be a wholly-owned subsidiary.

The CHAIRMAN. Can they control it? Can they have a 51 percent?

Senator BUMPERS. Mr. Chairman, Yes. But they can't own 80 percent or more or file a consolidated return with the smaller corporations.

The CHAIRMAN. Well, I appreciate your candor.

Senator Danforth?

Senator BUMPERS. One other thing, Mr. Chairman. I thought that was taken care of. I have been laboring under the delusion all

this time that we did not permit 51 percent ownership. I think we are going to have to go back to the drawing board on that issue.

The CHAIRMAN. That is an easy one to take care of.

Senator DANFORTH. Well, in this fairly intimate setting—because let's face it, this is not exactly a media event this morning; and because you have volunteered to go beyond your proposal—let me just ask you this—and I am not going to ask you to comment specifically on the President's program or the Ways and Means program or any of it—but you get the drift of what is happening. You know what the President's proposal is. You know what the Ways and Means Committee did.

The country has problems now. There is not any doubt about that. Do you think that any of these proposals floating around are going to really make America stronger?

Senator BUMPERS. Senator Danforth, yesterday afternoon Robert Reishauer testified before the Appropriations Committee that the middle class tax cut that the President proposed would probably generate between 0.1 and 0.2 percent growth in the GDP. I did not get a chance to question him at length about this.

But my own opinion is if you were take that same money and put it in highways, for example, it probably would generate considerably more growth than that. To answer your question, he also said that if we do nothing we are going to have a 3 percent growth rate this year. And he predicts in 1993 we will also have a 3-percent growth rate if we do nothing.

Now we have to make up our mind, is a 3 percent growth rate good enough for us. Is it enough to generate the kind of employment levels we want? The answer to that is no. Because in his same perspective he shows the unemployment rate, remaining static between 6.9 and 7.0 percent if we do nothing through 1992 and 1993.

That leads me to believe that we ought to do something for the middle class. But, you know, I could wax eloquent just as I do in all my Chamber speeches about this whole proposal, but I will just suffice it to say——

Senator DANFORTH. I am not suggesting—I mean I am not really asking you if we should do something or do nothing because I am not satisfied with the status quo either.

All I am saying is that we have had so much fanfare about all these various plans, various kinds of middle class tax cuts. There are various proposals. The President has a proposal. The Ways and Means Committee has a proposal.

But if you shook them all up in bag and then pulled out whatever came out of it and you looked at it and said, is this really worth the fanfare, wouldn't the answer be no? I mean it seems to me there are some obvious things we should do, but they have to do with making the country stronger. They have to do with creating something that is a future.

So you say, well, we are going to have a better future for the country. We are going to be stronger. We are going to be more competitive. We could do that if we wanted to. It would mean some pretty dramatic changes, I think, in the way the Tax Code is written.

But all this stuff, it seems to me, is nilch. I mean it is just so blatantly political. And I am not talking about one party or the other. I am talking about both parties. It is almost embarrassing to look at it.

Senator BUMPERS. Senator Danforth——

Senator DANFORTH. I have co-sponsored one of the plans, you know. It's almost to say, my God, my name is on that.

So I was just wondering and I say it—as I say—in this intimate setting.

Senator BUMPERS. It is not mine, so I can say anything I want to.

Senator DANFORTH. The world is not watching. Just between us on a bipartisan basis, could we not do something better than this stuff. I mean if we really wanted to. Not just make speeches.

Senator BUMPERS. Senator Danforth, I have always said if you would elect me king I would balance the budget in about 5 years. But no one seems to want to take me up on that.

I can tell you if you were to——

Senator DANFORTH. I was running for that.

Senator BUMPERS. And if you were to give me autocratic powers over the next 3 years I would come up with a better package in my opinion than anything that has come up so far. Not that I would be creative enough to come up with new concepts, but I think I could pick and choose among the things that would make us more competitive and create more jobs, and probably generate more revenue so the Treasury could reduce deficits.

I have to tell you I was a little bit disappointed in the President's State of the Union Address and I have gotten some mail from people saying, "you Democrats sat on your hands." "You were rude" and so on. I must say that the State of the Union Addresses have gotten entirely too raucous for me. I think it is sort of shameless. I thought that was rather shameless.

But I was disappointed in the President not saying, "look out Germany, look out Japan, here we come." You know, we are our own enemy. We must address our problems. We must become competitive. I thought that would be a real clarion call to the people of the country that they would have appreciated.

But the one thing I do want to say, and the Chairman of this Committee knows much more about this than I do, I was hoping the President would say we are, for example, going to spend the highway trust fund, we are going to spend 3 years of highway trust funds in the next two. We are going to ask all the highway departments of the country to accelerate their projects, get them going as fast as you can. Because as you know you create over 50,000 jobs for every billion you spend in that fund.

I thought it would have been the fastest thing we could do. The middle class tax cut, in the interest of fairness, if a proposal is made that I think does not cost too much, we figure out a way to pay for it, and we will readdress the issue of fairness, I will probably vote for it. But I can tell you I have admired those people who have had the courage to say, "this is not a solution." And the best economic thinkers are saying, this is not going to do anything for the economy.

Senator DANFORTH. Some are saying it would do more harm than good.

Senator BUMPERS. Well I can tell you one thing, these people, these economists who say do not try to cut the deficit this year because you just dig the hole deeper, I understand the economics of that. I understand the economic theory of that. But I don't happen to agree with it.

Because I think there are a lot of billions that can be cut where the economic impact would be very minimal.

Senator DANFORTH. Okay. Well, I thank you very much.

Senator BUMPERS. Thank you, Senator.

The CHAIRMAN. Senator Grassley?

Senator GRASSLEY. No questions, Mr. Chairman.

The CHAIRMAN. Well, I think that is very helpful to us, Senator. We are delighted to have the proposal.

Senator BUMPERS. Thank you, Senator.

The CHAIRMAN. Just making a side comment on the middle income tax cut, what you are saying is a very modest benefit to families insofar as economic stimulant it is minor, minor, no question about that. The only serious justification you can give for it is the question of fairness and trying to redress some of the things that happened in 1981 when you had the enormous drop in the personal income tax at the top rates. The middle income has taken some of the brunt of it.

What you have seen in the last decade is taxes going up and income going down for middle income. So it is a minor adjustment, but it is on a fairness issue, I think, principally; rather than on an economic stimulant.

Senator BUMPERS. Mr. Chairman, if I may bore you for 30 seconds longer to give you 30 seconds of my Chamber speech and their concern, usually they are anti-government, anti-tax, anti-regulation, so on, those people.

But I have used this illustration and it is a study I believe the Joint Tax, or CBO or somebody did, who said that in 1986 if you made $40,000—I believe it is $40,000—in 1991 you pay $100 more in taxes than you did in 1986. If you made $545,000 in 1986 and the same amount in 1991, you pay over $17,000 less than you paid in 1986.

The CHAIRMAN. That is correct.

Senator BUMPERS. I usually follow that, Senator, with a question saying, there is not a person in this audience—Democrat, Republican, conservative, liberal or in between—who agrees with that and thinks that is right. So that makes this tax set we are talking about very appealing.

I am not going to vote for it if it exacerbates the deficit. Unless we come up with an appropriate way to pay for it, I will not support it.

The CHAIRMAN. I share that.

Senator DANFORTH. Can I just add? This is $46 billion for $200 a person. I mean the fairness thing is all very interesting, but there is no support that I have found for it in any of its manifestations. None by economists, by the public. I just cannot find it.

I think the reason is that, sure everybody would like a couple hundred dollars or $300 or $500 for a child, whatever it is. People

would like that. But I think that people realize that what is more important than getting, you know, $1 a day or whatever it is is making the country stronger. That is what they want.

You know, I know that you are supporting the candidate who came in second in the Democratic primary in New Hampshire. What was interesting was the guy who came in first because his message was so unvarnished and it was just telling people what he conceived to be the truth.

One of those things that he was saying was he cannot play Santa Claus, as he put it last night. What an amazing message. People are not used to that. They turn out and vote for it.

I do not know, I am just one minority member of the Finance Committee—but I think that the public, the American people, really want us to do something to make the country stronger. That is what they want. I think that most people think this fairness thing, I guess everybody is not for fairness, but it just sounds like such a crock. What they really want is something that is real.

I think that we have a chance to do it, but it is an election year and besides the lines are drawn and it is kind of late in the game. So maybe it is too late to do it. But I would hope that some of us who are not running for anything would during this process say maybe we could do something big and something that is important, and something that has to do with the real need, which in my opinion is savings and investment and not encouraging a tax system which is based on stimulating consumption, which is what it is based on now, and more on encouraging the kind of thing that you were proposing with the legislation that you spoke of.

The CHAIRMAN. Well, I must say that when you talk about something that is less based on consumption, we can have quite a debate on that and I would be on the side of trying to lessen the consumption. So I share that very strongly.

Senator BUMPERS. Mr. Chairman, yesterday afternoon the same Robert Reishauer—I take that back, it was Dick Darman, yesterday morning, who testified for our Committee. He said what we need is investment and savings—savings and investment.

Well now, you know, we have all sat around here and talked about that. That flies right into the face of the President saying, go out and buy a new car. You cannot have it both ways.

The CHAIRMAN. Well, that is why I am supporting the return of the IRA, and I mean the full IRA, one where you get the deduction up front. I think that will help encourage savings in the country.

Senator, we are delighted to have you. We appreciate your comments.

Senator BUMPERS. Thank you, Mr. Chairman, and gentlemen. Thank you for inviting me.

The CHAIRMAN. Thank you. That is the end of today's hearing. Thank you very much for attending.

[Whereupon, the hearing was adjourned at 11:40 a.m.]

APPENDIX

Additional Material Submitted

Prepared Statement of Senator David L. Boren

Mr. Chairman, I appreciate the opportunity to discuss with you two components of the comprehensive legislative program that I introduced several weeks ago, The Tax Fairness and Competitiveness ACL. Today I want to emphasize two provisions in this act that I believe must be included in any economic growth proposal that this Committee adopts.

It is important that we be guided by one overriding principle as we discuss and draft legislation to stimulate the economy. While suggestions for a "quick fix" may be superficially attractive, we must not lose sight of important long-term objectives that will allow us to compete efficiently in the international marketplace. In the long run, we can ensure real economic growth and permanent economic health by using the tax system to encourage productivity in the workplace and to decrease the cost of capital.

With that objective in mind, I strongly suggest that this Committee adopt legislation that would provide the middle income taxpayer with relief, but that would not be counterproductive to our long-range economic interests. Proposals that result in additional income of approximately $1 a day do not meet that requirement—they do not enhance the position of middle-income Americans in the long run, and they are expensive in this period of fiscal restraint.

Senator Grassley and I have suggested a different kind of relief for middle-income citizens: a deduction or tax credit for interest on loans used to finance higher education. One of the most pressing financial burdens on middle-income Americans is the cost of financing their children's higher education. As I have often discussed with the members of this Committee, higher education expenses are typical of the double-bind in which many of these Americans find themselves. Students of limited means can qualify for scholarships and grants, and children of wealthy parents have no worries when it comes to paying for college. Middle-income parents, however, find themselves facing an average cost for college education of $6000 to $22,000 per year. With most of their net worth tied up in their homes, they have no choice but to take out substantial loans.

This is more than a question of middle-income tax relief, Mr. Chairman. The long-term economic health of this Nation depends on a skilled and educated workforce. The Federal Government has the obligation to do what it can, within the limits of our resources, to make higher education affordable for the largest segment of our society.

The legislation that Senator Grassley and I propose has two advantages over other student loan interest proposals being discussed. First, it allows a taxpayer a choice between a deduction and a tax credit, thereby helping those taxpayers who do not itemize. Second, because it is limited to loans for which the first payment is required to be made after December 31, 1991 and because it is further limited to interest paid during the first four months of repayment, it is a less expensive proposal.

Mr. Chairman, at this time I would request that written statements from various higher educational organizations and groups in support of our proposal be printed in the record. I have copies of statements from the American Association of University professors, institutions of higher education in Oklahoma, the Liaison Group for international Educational Exchange, the Student Loan Interest Deduction Restoration Coalition, and the deans of various Texas dental schools.

The second provision I wish to highlight today is one that looks to long-term economic policy. We in Congress have only recently focused on the unintended eco-

nomic effects of the alternative minimum tax. The AMT was designed to guarantee that profitable companies did not avoid paying any taxes. We did not intend it to result in a higher marginal tax rate on companies that had lower profits because of a recession, but that continued to make significant capital expenditures. Nor did we intend to penalize the ordinary and necessary business expenses of an important industry, the independent oil and gas industry. Yet both of these unintended effects appear to be occurring.

My proposal addresses these concerns. First, it would allow a company that had been paying the alternative minimum tax for three of the past five years to apply its accumulated AMT credits against its AMT liability. The AMT credit was originally designed to be a "prepayment" of tax that could be used to offset income once the company started paying regular corporate taxes again. Congress expected that a company would be an AMT payer for only a few years, so that the AMT credit would have value when it was available for use. That expectation has not proved to be accurate. Since 1986, a substantial number of companies have been paying the AMT for years, and they have no realistic hope of emerging from that position in the near future. Unless they can use the AMT credits that they have accumulated to offset their AMT liability, those credits will be of little value to them.

Second, our independent oil and gas industry has been devastated by the AMT. This industry drills 85 percent of the wells in this country; it is responsible for 60 percent of our natural gas and 40 percent of our oil. Put simply, this is a crucial industry, and its importance should have been brought home to us dramatically a year ago when this country went to war in the Persian Gulf in part to secure vital sources of oil. Our domestic independent industry is facing a crisis, however. The rig count, which is this industry's measure of drilling activity, reached its lowest level in history in January. How long are we going to wait to do something? How many more times will we be forced to put young Americans at risk before we encourage energy independence?

My proposal, which has also been introduced by Senator Breaux, is to eliminate two necessary business expenses—intangible drilling costs and percentage depletion—as tax preference items under the AMT. In this way, the independents would be treated like every other business that can deduct its ordinary expenses under either the regular or the alternative system.

Mr. Chairman, this Committee, this Congress, and the country face a challenge in the next few weeks. Our country is suffering from a short-term economic downturn, and we are concerned that over the longer-term we may not be able to compete in the world marketplace. I look forward to working with you to meet this challenge with a program that offers meaningful immediate relief for the middle-income and longer-term growth initiatives, such as reductions in the capital gains tax rate and modifications to the alternative minimum tax system.

PREPARED STATEMENT OF SENATOR JOHN H. CHAFEE

Thank you Mr. Chairman. I commend you for convening today's hearing on the health care proposals outlined in the Administration's Fiscal Year 1993 budget proposal. I am sure today's witnesses will have much to say, both about changes in the Medicare and Medicaid programs outlined in the budget, and about the President's recently released health care reform plan.

Health care has become a topic of increasing debate here in the Congress. Those without health insurance, an estimated 36 million Americans, have limited access to health care services. For those who do have insurance, the rising costs of health insurance is consuming an increasing percentage of their income. The current recession has only compounded the problem. As individuals lose their jobs, they lose their health insurance. Even those covered under Medicaid are not immune. As states struggle to meet their budgets, some have been forced to lower eligibility levels or cut back on optional services.

We have debated the issue of health care reform for decades. Some would like to see the Canadian system adopted in this country. Some advocate a requirement that employers offer health insurance. Still others believe that the federal government has little or no business getting further involved in health care and believe that market forces could solve the problems in our system. I'm sure there are advocates of each approach on this Committee.

There are also those who see the issue as a political football that can be used to score points against the opposing party during the upcoming campaign season. That is unfortunate. Health care reform is too important an issue to sacrifice for a few percentage points in the polls.

commend the President for submitting a proposal to reform our health care system. While we may not agree with every component of that proposal, it brings the Administration into the debate. Most members of this Committee have cosponsored legislation involving health care reform . . . whether it is the one introduced by the Democratic leadership, the proposal introduced by the Chairman of this Committee, or the proposal I introduced with 22 other Republican Senators.

In order to slow the rising costs of our health care system and provide critically needed health care services to the thirty-six million uninsured in this country, each of us must compromise. Clearly, there are a number of similarities between the different proposals . . . areas in which we could quickly reach agreement. Those areas include: insurance market reform, the establishment of small group purchasing organizations, 100% deductibility of health insurance premiums for self-employed individuals, increased funding for community health centers, reductions in administrative costs, state experimentation, encouraging managed care, and hopefully, medical liability reform.

We don't have to limit ourselves to these items, but I am suggesting that we begin with those areas of agreement and build upon them to develop significant reform in our health care system that will slow the growth of costs and provide services to all Americans. This will not be an easy undertaking. However, the time has come to set aside our ideological differences.

I commend the President for submitting his plan, and look forward to discussing the reform proposal, as well as changes in Medicare and Medicaid, with today's witnesses. I would especially like to thank Dr. Sullivan his role in advancing health care reform legislation. Thank you Mr. Chairman.

Prepared Statement of Dennis Crites

Good morning. I am Dennis Crites, a member of AARP's National Legislative Council from Norman, Oklahoma. I am pleased to have this opportunity to discuss the effect on older Americans of the President's fiscal year 1993 (FY 1993) budget proposal and his recently proposed health care reform plan.

The President's FY 1993 budget proposal is disappointing in a number of ways. First, the budget sends a harsh message to low-income Americans. The budget calls for a "modified freeze" on domestic spending, accomplished through sharp reductions in, or the elimination of, some important programs serving low-income Americans. The impact of these cutbacks is made more serious by the recession. Examples of proposed reductions in programs which assist low-income older persons include:

- a cut of over 90 percent in new construction for housing for the elderly under Section 202;
- a one-third reduction in the Low-Income Home Energy Assistance Program;
- elimination of the Community Service Block Grant; and
- a reduction of over $50 million in the Senior Community Service Employment Program.

The unwillingness of the President to use <u>at least part</u> of the money saved from reductions in defense spending to meet domestic needs means that low-income Americans are once again asked to sacrifice beyond their share and their means.

This budget will do little to dispel the public's growing cynicism about government in general and the federal budget process in particular. One of the positive attributes of the 1990 budget agreement was a general rejection of phony assumptions and budget gimmickry. Unfortunately, this budget too often uses these tactics "to make the numbers work." For example, the budget claims almost $40 billion in savings over five years from passage of reform legislation and related accounting changes for the Pension Benefit Guarantee Corporation and deposit insurance. This accounting change, from cash accounting to accrual accounting, may be good policy. What makes this accounting change suspect is using these "paper" savings to offset "real" revenue losses from the President's proposed tax cuts.

In the same vein, the budget's deficit numbers are based on the elimination of almost 250 domestic programs and unspecified savings in domestic programs in FY 1994 and FY 1995. Many of the programs slated for elimination have been targeted before; and, while Congress may well decide to prune some programs from the list, most will likely remain.

Like the Administration's FY 1993 budget proposal, the President's recently proposed health care reform plan falls far short of providing for the real needs of Americans. My testimony will begin by discussing some of AARP's concerns with the President's health care reform proposal and then turn to an analysis of the Administration's FY 1993 budget proposal.

THE PRESIDENT'S HEALTH CARE REFORM PROPOSAL

On February 6, 1992, President Bush acknowledged the need for reform of our nation's health care system and presented a proposal to the American public. AARP is pleased with this action since the Administration's formal entry into the health care reform debate significantly increases the odds that something will ultimately happen; the question now becomes how and when, not whether.

The President's proposal, however, fails to deal effectively with the two major problems -- intensified still further by the recession -- in our health care system:

- o access to both acute and long-term care services for all uninsured and underinsured individuals; and,
- o effective health care cost containment.

In addition, AARP firmly believes that the President's proposal to finance his plan through cuts in the Medicaid program and suggested cuts in the Medicare program are tragically misguided.

The following is an analysis of the various components of the President's health care reform proposal and what effects they would have on our health care system.

I. Acute Care Access: Tax Credit and Deduction Proposals

The President's plan attempts to provide greater access to acute health care coverage through several avenues, with the primary avenue being tax credits and deductions for the low- and middle-income. While use of the tax code can play a useful role, these credits and deductions fail to fully cover the average cost of a group health insurance policy. According to the Health Insurance Association of America (HIAA), an average conventional group health insurance policy in 1993 will cost **$2,445** for an individual and **$5,327** for a family (figures are from a 1990 HIAA survey of group plans adjusted by an average annual growth rate of 12 percent). The President's proposal would provide for a tax credit or deduction of only **$1,250** for an individual and **$3,750** for a family, as indicated below.

A. A "Transferable" Health Insurance Tax Credit For the Low-Income:

For low-income individuals and families, the President offers a transferable tax credit -- regardless of whether an individual or family has any tax liability -- for the purpose of purchasing health insurance. This tax credit could be worth up to:

- o $1,250 per individual;
- o $2,500 per married couple or other 2-person family; and
- o $3,750 per family of 3 or more.

The tax credit could be collected directly by the states who would then enroll these individuals and families in a health insurance plan which could either be part of the state's Medicaid program or a separate benefits package. Those not wishing to be enrolled in the state plan could opt to receive **a voucher** which would then allow them to purchase private health insurance on their own. Under either scenario, the individual or family would not have to wait until tax filing time to receive the voucher/credit. They could apply at any time at a state office

or a Social Security Administration office under state contract at any time during the year.

Eligible to receive this tax credit or voucher (when it is fully phased in by 1997) would be all individuals or families below 100% of poverty. (Initially, only those with incomes below 50% of poverty would be eligible.)

Those with incomes between 100% and 150% of poverty would receive a tax credit on a sliding scale basis, decreasing to 10% of the maximum allowable amount (i.e., $125/individual, $250/couple, and $375/family) at 150% of poverty.

B. A Health Insurance Tax Deduction for the Middle-Income

The President also proposes a tax deduction of health care premiums to aid middle-income Americans in purchasing health insurance. The deduction is worth up to:

- o $1,250 per individual;
- o $2,500 per married couple or other 2-person family; and
- o $3,750 per family of 3 or more.

Those with incomes between 150% of poverty and $50,000 for an individual, $65,000 for a couple, and $80,000 for a family would be eligible to take this special tax deduction. Those low-income persons who are eligible for the tax credit may choose to take this health insurance tax deduction instead.

C. Analysis: The Value of the President's Tax Credits And Deductions Compared To The Estimated Cost Of An Average Group Insurance Policy in 1993:

The value -- that is, what can be purchased in the health insurance market -- of the proposed tax credit and deduction is shown on Charts I, II and III (attached) for individuals and families with different incomes in 1993. The Charts compare the credit and deduction (assuming full implementation in 1993) to the estimated average cost of a group health insurance policy of $2,445 for an individual and $5,327 for a family in 1993. These estimates are based on the Health Insurance Association of America's (HIAA) 1990 survey of conventional group plans (adjusted by an estimated annual growth rate of 12 percent).

Chart I shows the value of the full tax credit for an individual and family with incomes below the 1993 tax filing thresholds. An individual with income under $6,100 in 1993 would be eligible to receive the maximum proposed tax credit of $1,250, or enough to purchase 6.1 months of insurance coverage -- leaving the individual to pay $1,195 to cover the cost of coverage for the remaining 5.9 months in the year. A family with an income of under $15,800 in 1993 would be eligible to receive the maximum proposed tax credit of $3,750, or enough to purchase 8.4 months of insurance coverage -- leaving the family to pay $1,577 for the remaining 3.6 months in the year.

Clearly, the tax credit is not sufficient to cover the estimated annual premium of an average group insurance policy in 1993. Moreover, the additional costs of copayments, deductibles, and services not covered under the policy would have to be paid by the policyholder.

Chart II shows the relative value of the proposed tax deduction for two single taxpayers in 1993, one with an annual income of

$10,000, the second with an annual income of $40,000. For the individual at $10,000, the $1,250 deduction (at the 15 percent tax bracket rate) is worth a mere $188 towards the estimated average group policy cost, or less than 1 month of insurance coverage.

An individual at $40,000 is only marginally better off. While the cost of the policy remains the same, this higher income individual receives a greater value for the same deduction (as a result of the higher 28 percent bracket), in this case $350. The $350 is worth approximately 1.7 months of coverage.

Chart III shows similar values for a family of four, with two examples at the $25,000 and $60,000 income levels. The 1993 estimated average annual policy cost for a family is $5,327. For the family with an annual income of $25,000 in 1993, the $3,750 deduction (at the 15 percent tax bracket rate) is worth $563, which would buy about 1.3 months of coverage.

The higher income family at $60,000 does better. For this family (at the 28 percent bracket), the deduction is worth $1050, or about 2.4 months of coverage.

II. Long-Term Care

What should be one of the most significant aspects of any health care reform plan is simply ignored by the President's proposal -- the long-term care needs of American families.

Not only are families emotionally and physically exhausted from providing informal care at home without any respite, they are also financially bankrupted by the staggering cost of providing nursing home care for a loved one. The institutional bias in the current system has also made it extremely difficult to receive affordable home health services. Clearly, the financial burden placed on families and individuals that pay for long-term care is no less devastating than it is for those faced with high acute care costs. A $30,000 nursing home bill is no less or no more burdensome than a $30,000 hospital bill. **AARP believes that long-term care must be an integral part of health care reform so that we can ensure individuals access to a full continuum of care throughout their lives.**

III. Managed Care

One of the "principles" of the President's proposal is to "promote consumer choice." His plan, however, relies heavily on managed care, which limits health care choices by requiring many patients to use only pre-selected health care providers.

While many managed care plans do provide quality care at lower costs, the problems of underservice and lower quality of care in capitated programs are well documented. Government investigations have found numerous problems with the delivery of quality care at several managed care sites. We are concerned that the Administration's plan speaks only to the cost-saving potential of managed care but is silent on a vital beneficiary protection -- the existence of strong quality assurance measures to ensure that managed care recipients receive high quality services. Unfortunately, the poor and the elderly have been the major victims of unscrupulous managed care providers.

Based on this, **AARP believes it is inappropriate to promote managed care for poor, elderly, and disabled Americans without at a minimum strong quality assurance provisions that ensure they**

receive proper care. There remains the overwhelming question of whether such an approach to care -- one which has the limitation of choice as its cornerstone -- is acceptable to many Americans.

IV. Health Care Cost Containment

Unfortunately, the President's proposal would do little to control escalating health care costs -- the foremost issue on the minds of the American public. With the exception of the proposal to shift health care delivery to a more market-based system -- a strategy which has been remarkably unsuccessful over the last several decades -- the President's plan ignores total health care costs. Rather, it seeks only to control the federal government's payment for health services by:

- limiting the value of health tax credits and deductions;
- suggesting cuts in Medicare reimbursement rates;
- cutting federal payments for Medicaid; and
- imposing managed care requirements on Medicare and Medicaid.

In short, the President's proposal attempts to protect federal payments for health care but does nothing to contain total health care spending. In effect, this is the approach taken over the last decade -- with no success in curbing health care costs in the economy.

The President's plan, at a minimum, will create further cost shifting. The proposal may even contribute to escalating health care costs by allocating Medicare and Medicaid resources to the credits and deductions ultimately payable to private insurance -- which has fewer controls on reimbursement rates than Medicare and Medicaid. Without such controls, the tax credits and deductions could actually be an incentive to insurers to raise their prices. The Administration needs to recognize that the health care cost problem is not just a problem with federal spending -- any health care reform plan must effectively address total health care costs.

V. Insurance Market Reforms

The Association has a particular interest in insurance market reform because of the impact it may have on many of our members. Half of AARP's members are between the ages of 50 and 65, a vast majority of whom are either working or dependents of workers.

In his proposal, the President makes lofty promises about the improved accessibility and affordability of private health insurance. Unfortunately, while his stated objectives are a step forward, the proposal falls far short of these ideals in its specifics. For example:

- Access: For individuals in groups, the proposal would require that every insurer be required to accept every employer group in the state that applies for coverage, but it does not mandate that employers apply, and it specifically rejects any requirement that employers be required to administer the plan or contribute to the cost of coverage. Under such a proposal, any expanded access would be completely reliant upon an employer's willingness to offer coverage (i.e., to make it available, but not necessarily pay for it) and on the worker's ability to pay for it. Further, the market reforms do not apply to individually purchased insurance.

- Coverage: The proposal would apply the ERISA preemption, that allows larger self-insured firms to avoid state mandated benefit requirements, to small business. While some of these mandates have become excessive, the Administration's proposal offers no substitute that would serve as a basic package. Thus, there is no assurance that those individuals who might be able to obtain coverage through these reforms would have an adequate basic benefit package made available to them.

- Cost Containment: The proposed market reforms rely on marketplace competition as their principle means of cost containment, but history can only document the private sector's lack of success in this area. **AARP supports private insurance market reform, but in the context of comprehensive health care reform that has universal access and effective cost containment at its foundation.** Since the Administration's proposal does neither of these, the insurance market reforms that it proposes create an expectation that it cannot live up to.

VI. Medical Malpractice Reform

The President's proposal also seeks to control costs through medical malpractice reforms. While some reforms in this area are warranted, they would not result in dramatic cost savings within the total health care budget. The American Medical Association (AMA) has estimated that the combined cost of medical malpractice insurance and defensive medicine represent only two to three percent of national health care spending.

AARP believes that a fair and workable reform of our malpractice system must recognize, first and foremost, that the root problem is medical negligence. Quality assurance mechanisms which seek to identify and eliminate negligent care and to correct poor performance should be coupled with tort system and insurance reforms.

Real malpractice reform should address each of these components and should not look to any one avenue alone to produce significant changes. Further, we should avoid creating a new set of perverse incentives as we attempt to eliminate old ones. For instance, reliance on limits on non-economic damages may have some merit, but its greatest impact would fall on older Americans -- a group that has high exposure to the health care system but historically low malpractice awards. Similarly, alternative dispute resolution (ADR) strategies are very important, but they should not jeopardize an individual's constitutional recourse to the courts in cases where other mechanisms have failed to address serious medical negligence.

VII. Administrative Savings and Paperwork

The President's proposal also seeks to contain health care costs by streamlining administrative paperwork. **AARP believes that such reforms have merit and could achieve savings;** however, the savings achieved could be much greater through comprehensive reform that includes the establishment of uniform reimbursement rates for all payers and providers.

VIII. Medicare and Medicaid Cuts

The President's plan calls for deep cuts in the Medicaid program and suggests further substantial reductions in Medicare.

Ultimately, cuts of the magnitude suggested would cause beneficiary care to decline and jeopardize the integrity of these important programs.

AARP believes these cuts are totally unacceptable to finance the limited reform envisioned by the Administration. The Administration is asking the elderly, disabled, and poor, as well as the providers that serve them, to pay for a more fragmented and less equitable health care system. Clearly, the elderly, disabled, and poor who have medical problems should not be the source of financing medical care for other Americans. **AARP believes that this approach is drastically misguided.**

In Medicare, the suggested cuts in provider reimbursements will only perpetuate cost-shifting and provider resentment. A recent survey indicated that 75 percent of older Americans are already worried about losing government-provided health insurance. Compared to the rest of our health care system, the Medicare program works well in terms of providing access to all that are eligible.

In addition, Medicare has a number of cost containment mechanisms in place that have worked to control its program costs -- though this has resulted in some cost shifting to private payers. **AARP believes that the only way to curtail cost-shifting and reduce fragmentation is through comprehensive reform that establishes a fair and uniform method of reimbursement across all payors.** The Medicare program can serve as a useful model for such reform.

The Administration's proposal depends on the Medicaid program, or some variation of it, to provide coverage for the nation's poorest individuals. The plan, however, would cap federal Medicaid payments to states and allow for annual increases of no more than two to four percent more than the general rate of inflation -- at a time when Medicaid costs are growing at over three times that rate. Since the President's plan does little to control overall health care costs, a cap on Medicaid spending would only decrease benefits for the most vulnerable Americans and/or increase the financial strain on state budgets. **In effect, the Administration's proposal is nothing more than a cost shift to the states, at a time when most states can ill-afford the additional financial burden.**

In addition, the Administration's plan would encourage Medicaid-eligible individuals to use a tax credit to buy a basic private insurance benefit package, either independently or through an employer. The plan requires the states to determine the content of the basic benefit package based on the value of the tax credit. Given the limited amount of the tax credit, the basic benefit package may well cover far less than the current benefits available under the Medicaid program -- especially in high-cost areas. Also, since the Administration's plan does not contain costs, private insurance prices will continue to escalate and erode the purchasing power of the proposed tax credit. (The credit is indexed to general inflation, not medical inflation, which has been running at two to two and a half times general inflation.)

THE PRESIDENT'S FY 1993 BUDGET PROPOSAL

I. BUDGET PROCESS

The President's budget proposes a series of "budget process reforms". These include:

- extending the structure and enforcement procedures of the Budget Enforcement Act (BEA) until "the budget is balanced,"

including the continuation of 1) the existing discretionary spending categories and their limits and 2) the pay-as-you-go requirements for mandatory programs;

- o establishing caps for mandatory programs; and
- o changing the rules on sequestration.

Due to the magnitude of cuts and revenues in the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), too little attention was paid to the provisions of the BEA. For this reason, it is especially important for Congress to now thoroughly examine and debate the BEA before any decision is made about modifying or extending its structure and enforcement mechanisms.

Even before the BEA, expansion of entitlement (mandatory) programs was governed by informal pay-as-you go requirements. This committee, its counterpart in the House, and many of the interest groups working on entitlement programs (including AARP) recognized that proposals had to be deficit neutral or they would not be adopted.

It is interesting to note that while the President's budget proposes changes that would make pay-as-you-go an even more restrictive system, the health care proposal introduced by the President does not include specific financing mechanisms.

Discretionary Spending Caps

Clearly, Congress should examine whether or not to continue separate discretionary caps for defense and domestic programs in light of the vast changes that have taken place in the world. The President's FY 1993 budget uses all of the savings from defense for deficit reduction, with no money redirected to meet pressing domestic needs. AARP believes that deficit reduction is important and must continue to be one of the nation's primary policy goals. But the wisdom of cutting defense spending in a recession and not shifting any of the money back to the civilian economy is at best questionable. The first order of business is to get the economy growing again.

A major threat to older Americans is masked under the innocuous rubric of "budget process reform." One of the most obvious of these threats is the proposed cap on mandatory programs. The President proposes capping mandatory programs by limiting growth to the growth in the eligible population, the Consumer Price Index, plus an average of 2.5 percent (before health care reform) and 1.5 percent (after health care reform). If growth in mandatory programs were to exceed these levels, reconciliation would be triggered. If reconciliation failed to bring program growth back to the capped level, a sequester would be triggered. This proposal seems to assume that all entitlement programs would be subject to the caps.

Unquestionably, the real target of this proposal is Medicare and possibly Medicaid, since the growth in health care costs generally and in the federal budget has far exceeded general rates of inflation. But, the mandatory cap does nothing to address the uncontrolled growth in health care costs. Since the early 1980's Congress has subjected Medicare to a series of cuts. These efforts have slowed the rate of growth mainly on the Hospital side of the program. Despite these efforts, it has not been possible to keep the rate of growth near the general inflation rate. A mandatory cap would simply require ever sharper cuts in Medicare without any regard for the overall effectiveness of the program.

Another attack on Medicare and other programs of interest to older Americans in the budget process reform is a major change in sequestration. Under current law, many entitlement programs, such as low-income and civil service retirement and health benefit programs, are not subject to automatic cuts to meet deficit targets. Currently, Medicare is sequestrable, but the amount of any automatic cut is limited to 4 percent of program costs. (This was an increase from two percent under the Gramm-Rudman-Hollings sequester rules.) The budget proposal would eliminate most exemptions from sequestration, thereby "uncapping" the Medicare sequester.

Since the enactment of the first Gramm-Rudman-Hollings law, Congress has protected most low-income entitlement programs from automatic reductions. Unless we are to believe that Congress would abandon this commitment to ensure that low-income individuals would not suffer from deficit reduction efforts, the bulk of any savings (70 percent or more) from either the entitlement cap or sequestration would come from Medicare and civil service retirement.

Any plan to subject Medicare to full sequestration, particularly at these levels, would be a fundamental attack on the program, even without adopting the proposal for caps on mandatory programs. Combined with the mandatory caps, a full sequestration of Medicare would be devastating for the future stability and security of the program. In this instance, Medicare would be subject to two rounds of reductions, without any limit on the amount that could be cut from the program.

These proposed budget "reforms" are unwarranted and unwise, especially at a time when there is heightened concern on the part of older persons about losing Medicare benefits. Indeed, a recent survey conducted by the Daniel Yankelovich Group (DYG) for AARP shows that 75 percent of older persons express a fear of losing government health insurance.

No one should be misled by what appears to be arcane technical modifications to the Budget Enforcement Act. They will be seen for what they are -- an all out attack on Medicare.

II. HEALTH CARE PROGRAMS

Overall, the President's FY 1993 Medicare and Medicaid proposals are similar to those he proposed last year -- and were soundly rejected by the Congress.

A. Medicare

Under the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), the Medicare program continues to make enormous contributions to federal deficit reduction. OBRA '90, enacted in the Autumn of 1990, included a five-year deficit reduction plan which will reduce Medicare benefit outlays (Parts A and B combined) by a total of $43 billion by the end of FY 1995. In FY 1993alone, OBRA '90 will reduce Medicare benefit outlays by an estimated $8.9 billion.

Now, in addition to the substantial Medicare cuts enacted in OBRA '90, the President's FY 1993 budget proposes to cut the Medicare program by another $1.4 billion in FY 1993 and $13.9 billion over the next five years (FY 1993-97) -- (see Chart IV). In addition, the Administration proposes to require all state and local workers to participate in Medicare, bringing

in $1.6 billion more in revenue in FY 1993 and $7.5 billion over the next five years (FY 1993-97).

Higher Part B Premium for Upper Income Beneficiaries: The budget proposal would raise $3.1 billion in new revenue over six years (FY 1992-97) by tripling the cost of the Medicare Part B premium for upper income beneficiaries (from $31.80 per month to $95.40 per month in 1992). Specifically, beneficiaries with annual incomes over $100,000 ($125,000 for couples) would have $95.40 deducted from their monthly Social Security check presumably beginning August 1, 1992, to pay for their Part B premium.

This proposal is similar to those opposed by AARP and rejected by the Congress both last year and during the 1990 budget summit. Income-relating Medicare premiums does nothing to contain escalating program costs. Rather, it merely shifts those costs onto beneficiaries who have no control over Medicare spending.

Medicare Coverage of State and Local Employees: The budget proposal includes $1.6 billion in new revenue for FY 1993 by requiring that all state and local employees and their employers (state and local governments) pay the Medicare Hospital Insurance (Part A) payroll tax (1.45% of payroll) beginning July 1, 1992. Currently, all state and local employees hired after April 1, 1986 are required to participate in Medicare Part A. The President's proposal would require participation by those hired before that date. Since an estimated 75 percent of those non-participating state and local workers will eventually receive Medicare benefits (through a spouse's record or limited Medicare-covered employment), **AARP believes this proposal is fair and equitable, although the revenues should be used to pay for health care.** [Inclusion of all state and local employees in Social Security and Medicare is a long-standing policy of AARP.]

Medicare Provider Reimbursement Constraints: As in the past, the Administration's FY 1993 budget proposes significant reductions in Medicare provider payments. A total reduction of $1.1 billion in provider reimbursement in FY 1993 and $10.8 billion over the next five years is proposed. Specific proposals include:

- Medicare Part A (Hospital Insurance). The Administration proposes $630 million in reductions in payments to hospitals in FY 1993 by moving the effective date for the annual Prospective Payment System (PPS) update from October 1 to January 1. AARP views this proposal as a budget "gimmick" aimed at saving money by simply "sliding" effective dates.

- Medicare Part B (Physician Services). The Administration proposes $410 million in reductions in Part B spending in FY 1993. This includes: 1) a $310 million reduction in reimbursements for laboratory services; and 2) a $100 million reduction in Medicare payments to nurse and physician anesthesia teams. The Administration's proposal for anesthesia services, which would make payment rates for nurse anesthesia teams comparable to rates received by individual physicians who provide the same services, is essentially consistent with the position taken by the Physician Payment Review Commission in its 1991 Report to Congress. **AARP believes, however, that any reductions in provider reimbursements should not jeopardize physician payment reform.**

- Other Medicare Services. The Administration proposes a $20 million reduction in Medicare provider reimbursement for durable medical equipment (DME) in FY 1993. **AARP supports initiatives aimed at reducing fraud and abuse in Medicare DME reimbursement. We, however, await the details of this proposal to determine its appropriateness.**

Medicare Contractor Reform: The Medicare program is administered through private organizations, usually commercial insurance companies, which are referred to as contractors -- Medicare Part A contractors are known as "fiscal intermediaries," Part B contractors as "carriers." The proposed budget includes several measures to encourage contractors to manage the Medicare program more efficiently. **AARP supports many elements of this "contractor reform," but such efforts must not impede adequate funding for toll-free hotlines for beneficiaries.** In addition, AARP believes that adequate funding should be included in the budget to revise the Explanation of Medicare Benefits (EOMB) form to include specific information on the balance billing limit.

Further, the proposed budget would eliminate carrier bonuses for increasing the number of Medicare participating physicians -- that is, doctors who agree to accept Medicare payment rates as payment-in-full. **AARP opposes eliminating these bonuses.**

Medicare and Medicaid Research, Demonstration, and Evaluation: The FY 1993 proposal gives priority in its HCFA research budget to refining the new physician payment system to ensure its successful implementation and to evaluate its impact on utilization, access and appropriateness. **The Association applauds this focus as essential to the implementation of the 1989 Physician Payment Reform law.**

While research has traditionally been a small but important part of the budget, the FY 1993 budget requests only $36 million for research, demonstrations, and evaluation, a $42 million reduction (54 percent) from FY 1992. Although some research is paid for in other areas of the budget, a cut of this magnitude could significantly undermine important research efforts, such as those that made hospital prospective payment and the resource-based relative value scale possible. It could also make it difficult to adequately fund the monitoring and evaluation activities required in the Physician Payment Reform legislation, despite their priority status in the proposed budget.

B. Medicaid and Other Health Programs

The Medicaid Program: The President's FY 1993 budget proposes a savings of $5 million in the Medicaid program by requiring states to ensure that noncustodial parents' health insurance provides medical support for their children, thereby requiring private health insurance to provide medical support instead of Medicaid.

AARP believes that this proposal could help provide health insurance to some of America's most vulnerable children.

Survey and Certification Fund: The proposal would raise $255 million in new user-fees by establishing a survey and certification revolving fund to charge facilities for costs associated with federally-required quality surveys under Medicare and Medicaid. **AARP opposes charging survey and certification providers such "user-fees" which could weaken state survey agencies at a critical time when major long-term care quality reforms are being put in place.** Such fees may also create incentives for providers to shift costs onto private-pay patients, further escalating out-of-pocket costs.

Breast and Cervical Cancer Prevention: The Administration recommends an increase in funding for breast and cervical cancer screening for low-income, as well as non-Medicaid, uninsured women. **AARP commends the Administration for this proposal, which could help reduce the number of deaths from these types of cancers.**

III. RETIREMENT INCOME SECURITY

A. Social Security

Through Social Security, the federal government provides retirement income to over 30 million older Americans who worked in Social Security-covered employment. The government also provides retirement benefits to federal workers -- the largest category of workers outside Social Security. Once again, the President's budget provides full cost-of-living adjustments (COLAs) for both of these retirement income programs. A full COLA enables older Americans to keep pace with the rising cost of goods and services.

The President's FY 1993 budget includes a welcome, albeit modest, increase in the administrative funds for the Social Security Administration (SSA). Unfortunately, the President proposes a freeze on SSA staffing for FY 1993.

Despite an increase of 1,000 full time equivalent (FTE) staff permitted under the FY 1992 budget, the agency's disability application backlog rose and the toll free 800 telephone number experienced continued problems. These and other service delivery problems are an outgrowth of an OMB-ordered 17,000 FTE staff cut (see Chart V) that took place from 1985 through 1990.

B. Supplemental Security Income (SSI)

SSI provides a sub-poverty level income for low-income persons who are elderly, blind or disabled. The President proposes a $129 million reduction in SSI spending over five years by recouping SSI overpayments from Social Security beneficiaries. This proposal, which has been rejected by Congress previously, would create serious financial hardship and anxiety, because most beneficiaries already have inadequate incomes.

C. Pensions

Pension Benefit Guaranty Corporation (PBGC): The PBGC provides mandatory insurance of pension benefits to defined benefit plan participants if an employer terminates a plan and is unable to pay benefits. The President's FY 1993 budget includes proposals to change the budgetary treatment of PBGC and proposes legislation to reduce PBGC's future exposure.

The Administration proposes to account for PBGC in the federal budget on an accrual, rather than on a cash, accounting basis -- this will show the present value of PBGC's estimated future obligations. In other words, costs are to be measured as they arise, not later when they are paid. The Administration also proposes three-part legislation to reduce PBGC's future liabilities. The legislation would make improvements to the current minimum funding rules, freeze guarantees for currently underfunded plans, and enhance PBGC's standing and recovery from employers in bankruptcy.

The cumulative effect of changing to accrual-basis accounting and implementing the proposed legislative changes would be to lower the PBGC's accrued "cost" in the federal budget by $8.7 billion in the first year. This figure is reached despite the fact that assumptions of future obligations are quite uncertain. Furthermore, the proposed first year savings far exceed current PBGC obligations, making it unclear exactly where these savings would come from.

Retirement Plans and Distributions: The Administration proposes a number of measures to change pension distribution rules and would encourage employers to sponsor pension plans. The Administration proposes the creation of a simpler pension plan option, with less paperwork and less stringent nondiscrimination testing. In addition, it would ease rollovers to Individual Retirement Accounts (IRAs) and phase-out current preferred tax treatment of pension distributions.

AARP believes that any changes adopted should also ensure the maintenance of equitable benefits to lower-income workers.

Real Estate Investment by Pension Funds: The Administration proposes to modify the rules on pension investments in real estate. These changes are intended to facilitate direct equity investment in real estate by decreasing the taxation of debt-financed investments. Although current pension law does not specifically prohibit investment in real estate, current fiduciary rules of prudence and diversification often limit such investment. **Retaining current fiduciary standards are essential to ensure that favorable tax changes do not adversely affect pension funds.**

CHART I

Value of The President's Tax Credit Compared to The Cost of An Average Conventional Insurance Policy in 1993

Annual Average Policy Cost for an Individual

$2,445

Value of Tax Credit

$1,250

(Buys 6.1 Months of Coverage)

Individual With an Annual Income Under $6,100

Annual Average Policy Cost for a Family

$5,327

Value of Tax Credit

$3,750

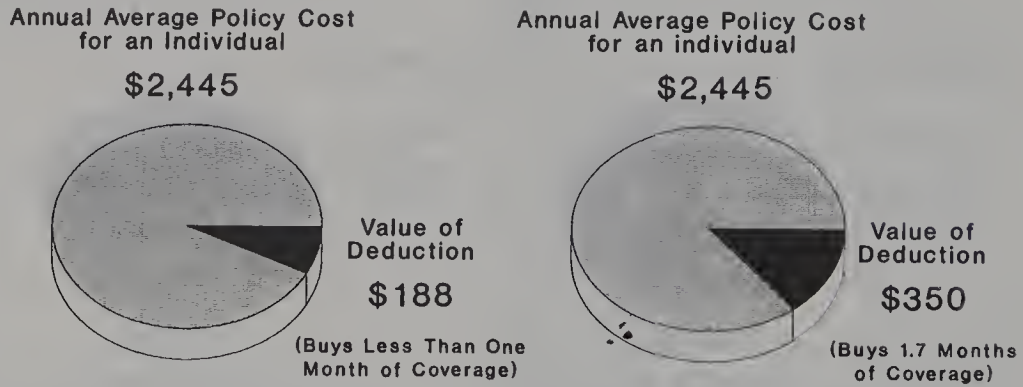
(Buys 8.4 Months of Coverage)

Family With an Annual Income Under $15,800

Ave. policy cost based on HIAA's 1990 survey for group plans adjusted by an annual growth rate of 12 percent

CHART II

Value of The President's Tax Deduction Compared to The Cost of An Average Conventional Insurance Policy in 1993



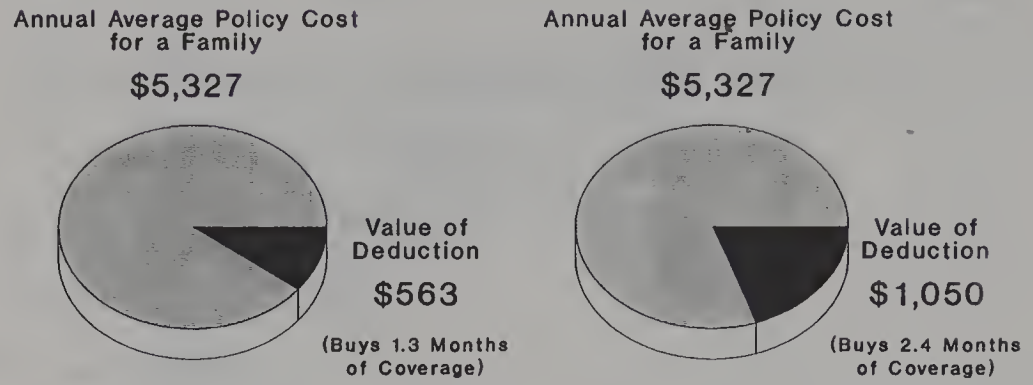
Single Individual With an Annual Income of $10,000

Single Individual With an Annual Income of $40,000

Ave. policy cost based on HIAA's 1990 survey for group plans adjusted by an annual growth rate of 12 percent

CHART III

Value of The President's Tax Deduction Compared to The Cost of An Average Conventional Insurance Policy in 1993



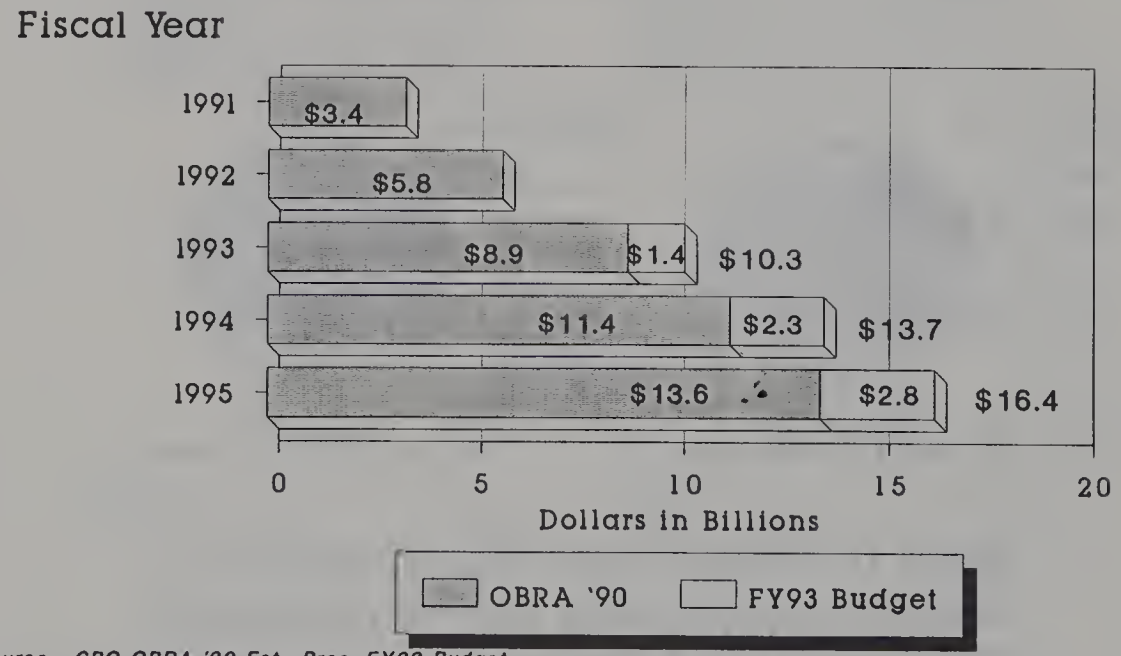
Family With an Annual Income of $25,000

Family With an Annual Income of $60,000

Ave. policy cost based on HIAA's 1990 survey for group plans adjusted by an annual growth rate of 12 percent

CHART IV

Medicare's Continuing Contribution to Deficit Reduction FY91-95

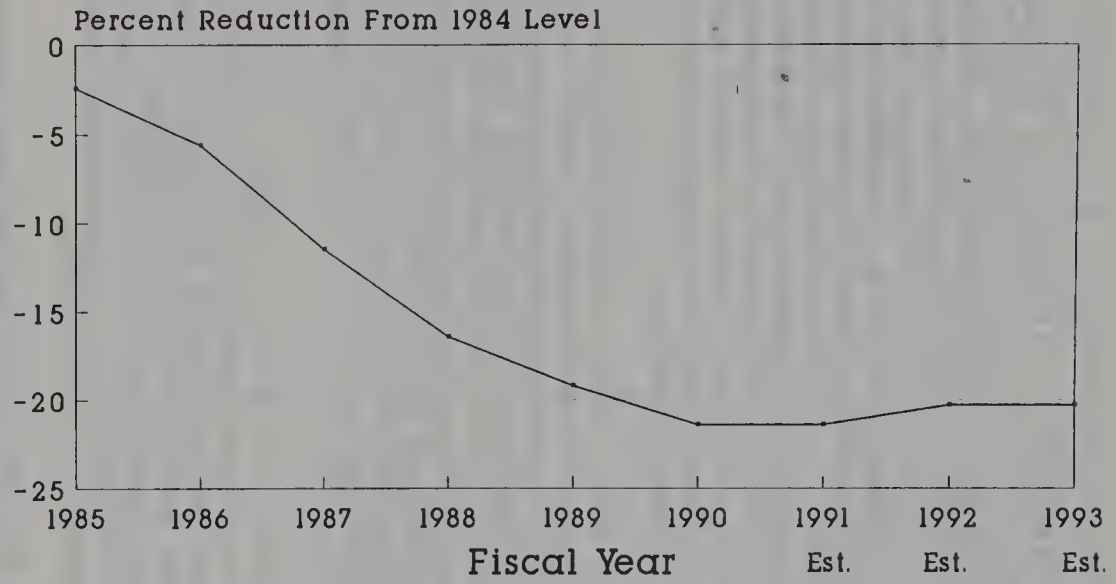


Source: CBO OBRA '90 Est.; Pres. FY93 Budget; includes proposed High income Part B premium and Parts A and B provider cuts.

MHK-BUD6-1/29

CHART V

Social Security Administration
Full Time Equivalent (FTE) Staff
At End of Fiscal Years 1985-93



1984 FTE Level = 79,951. Source: 84-90
House Sub. on Ret. Inc./91-93 HHS
DD-8-SSAFTE-1/29

PREPARED STATEMENT OF G. W. N. EGGERS, JR.

I am G.W.N. Eggers, Jr., M.D., Chairman of the Department of Anesthesiology at the University of Missouri at Columbia and President of the American Society of Anesthesiologists (ASA). On behalf of the ASA, which represents more than 30,000 physicians nationwide, I appreciate the opportunity to discuss President Bush's fiscal year 1993 (FY 93) budget proposals. Even though the specialty of anesthesiology has been subjected to a towering list of Medicare reductions in the past decade, culminating with a 29 percent cut under the new Medicare Fee Schedule, the Administration is once again targeting anesthesia services. The Office of Management and Budget (OMB) proposes to sharply reduce payments for anesthesiologists working with certified registered nurse anesthetists (CRNAs) by in effect eliminating the portion of the fee historically apportioned for medical direction.

When an anesthesiologist medically directs CRNAs providing care in more than one surgical case concurrently, Medicare reimbursement is as follows: the CRNA is paid by applying a fee schedule conversion factor to full base and time units and the anesthesiologist is paid by applying a fee schedule conversion factor to reduced base units and half of the time units. OMB proposes to eliminate this congressionally-mandated methodology for the anesthesiologist and limit the medical direction fee to the difference between the payment if the anesthesiologist had personally performed the service and the fee schedule payment to the CRNA. (An example of the proposal is discussed later.)

ASA opposes OMB's proposed reduction in medical direction payments which would mean reimbursement reductions of greater than 50 percent for anesthesiologists who do not employ the CRNAs they medically direct, and about 30 percent for those who employ the CRNAs. This policy would, by providing such a perverse incentive, dictate employment relationships and jeopardize the continuation of the care team, which is the predominant mode of anesthesia care in this country.

This is not a new initiative, but one which the Administration has recommended -- and the Congress rejected -- over several budget cycles. The proposal is inequitable, unnecessary and should again be rejected.

ASA's statement will address the background of recent reductions in Medicare reimbursement for anesthesia services, the history of this particular proposal, the importance of the anesthesia care team, the need for medical direction and our concern with the OMB recommendation to virtually eliminate payment for medical direction.

MEDICARE SAVINGS FROM ANESTHESIA SERVICES

ASA has worked with this Committee over the years to achieve significant budget savings. We certainly never welcomed reductions but we have been realistic and have always offered alternative savings proposals in response to various OMB initiatives. There has to come a time, however, when the end is reached, and this year, after the unanticipated 29 percent reduction under the Medicare Fee Schedule (MFS), ASA must state

that time has come. Consider the past six years of Medicare reductions for anesthesia services:

•OBRA '86 ratified HCFA regulations halving the base units for cataract anesthesia from 8 units to 4 units. Five year savings: $405 million.

•OBRA '87 mandated base unit reductions for those anesthesiologists medically directing nurse anesthetists: Three year savings: $35 million.

•OBRA '89 mandated the use of actual anesthesia time, as opposed to rounding up to the next whole unit: Five year savings: $245 million.

•OBRA '90 cut the average anesthesia prevailing conversion factor by 7 percent, applied on a zero to 15 percent sliding scale and extended the base unit reductions for medical direction services: Five year savings: $285 million.

•Medicare Fee Schedule: Anesthesia services receive the largest reduction of *any* specialty -- minus 29 percent for operating room services.

These reductions are all the more dramatic because anesthesia services account for less than 5 percent of Medicare allowed charges, or about $1.2 billion per year. In fact, a recent article in the Journal of the American Medical Association (JAMA) reviewed the growth in Medicare allowed charges from 1985 through 1988. During that period allowed charges for anesthesiology increased at a significantly lower rate than other specialties:

	Average Annual Growth Rate (%) 1985 through 1988
Anesthesiology	7.7
All physicians	12.3

This data not only shows the effects of the fee freeze, OBRA '86 and OBRA '87 reductions, but illustrates the anesthesiologists' inability to increase volume in response to payment reductions per service. Remember that this data does not even include the more severe reductions since 1988, particularly the 29 percent cut imposed by the Medicare Fee Schedule. There is no rationale for further cuts to this specialty.

MEDICARE PAYMENT FOR MEDICAL DIRECTION

This recycled proposal from OMB to cap payments to the anesthesia care team does not take into account either the significant reductions already imposed on the specialty, nor the congressional history of reimbursement for medical direction payments, CRNA payments, and support of the care team mode of practice.

It has been the intent of Congress to provide an incentive for medical direction and utilization of the anesthesia care team. In 1983, the hospital prospective payment system mandated payment options for nurse anesthetists specifically so that there would be no disincentives to

utilization of CRNAs in very small, rural hospitals or of the care team in other settings. Therefore, prior to implementation of the CRNA Part B payments in early 1989, the reimbursement for care team anesthesia was determined as follows:

> If the anesthesiologist employed the CRNA, the anesthesiologist billed as if the case were personally performed. The CRNA salary/benefits was paid out of the physician billings.
>
> If the hospital employed the CRNA (or the CRNA was self-employed), the anesthesiologist billed on the basis of 30-minute, vs. 15-minute, time units; this time differential was considered to account for the "cost of employment." The CRNA was paid under Part A via a DRG pass-through.

•OBRA '86 mandated direct Part B payment to certified registered nurse anesthetists (CRNAs), to be effective in 1989.

•OBRA '87 mandated cuts in medical direction payments for concurrent procedures which reduced the base units by 10 percent in the case of two procedures; 25 percent in the case of three procedures; and 40 percent in the case of four procedures. The Congress placed a sunset on this provision, thereby opening the issue for discussion again in 1990. ASA <u>supported</u> this provision in the context of the 1987 reconciliation process.

•In 1989 the CRNA Part B fee schedule was implemented.

•OBRA '89: OMB proposed to revise and expand the OBRA '87 reductions to 30 percent, 40 percent, and 50 percent respectively, and apply the reduction to the total charge (base and time units).

> This proposal was <u>rejected</u> by the Senate Finance Committee and the House Committees during the FY 90 budget process.

•OBRA '90: OMB again proposed reductions in payment for medical direction, in the form of a cap on total payment to the anesthesia care team (that is the total to the CRNA and the anesthesiologist) at the amount which would have been paid if an anesthesiologist alone had provided the care.

> This proposal, the same one being discussed today, was <u>rejected</u> by the Senate Finance Committee and the House Committees. The Congress chose instead to extend the OBRA '87 reductions until January 1996.

•OBRA '90 also increased the CRNA fee schedule at a cost of $385 million over five years. *The fact that Medicare pays more for a care team anesthetic than for one which is personally performed is attributable to the advent and increase in Part B reimbursement for the CRNAs, while anesthesiologists have seen payments reduced each year.* However, as the Congress considered both medical direction and CRNA payment revisions in the same legislation, the resulting increases in care team payments were apparently viewed as necessary to maintain the needed care team delivery system.

•FY 92. OMB again proposed the cap, or single fee for anesthesia services, in the budget. There was no reconciliation bill in 1991.

ANESTHESIA SERVICES AND MEDICAL DIRECTION

We would like to comment briefly on the components of an anesthetic service because we believe this speaks directly to the differences between anesthesiologists and nurse anesthetists and the subsequent need for medical direction. The issue of payment to the care team turns on the need for medical direction.

Anesthesiology is a specialty based on sophisticated pharmacologic and physiologic interaction: patient safety must always be at the forefront. Patient care in anesthesia involves three distinct phases, all of which constitute the practice of medicine and require the knowledge and training of a qualified physician. The preoperative phase involves a physical examination and history with particular reference to previous anesthetics, concomitant diseases and drug therapy, ordering and interpretation of non-routine tests, and prescription of drugs to implement the anesthesia plan.

The intraoperative phase includes the medical management of the patient's care from anesthetic induction through emergence, including monitoring and sustaining the patient's vital functions, as well as diagnosing and immediately treating any life-threatening complications. The anesthesiologist is also responsible for the post-operative care during the patient's recovery from anesthesia.

The respective training and clinical capacities of anesthesiologists and CRNAs are significantly different. Although the technical tasks performed by practitioners in the two disciplines can and do overlap, the critical distinction lies in the anesthesiologist's capacity to form and apply medical judgments.

ANESTHESIA CARE TEAM

The anesthesia care team mode of practice provides efficient and safe anesthesia care. It developed for a number of reasons, including regional and institutional preferences and the simple fact that there have never been a sufficient number of anesthesiologists to provide care for all surgical patients. The specialty has grown at a healthy rate, but we do not believe there will ever be enough anesthesiologists, particularly in rural and inner city hospitals, to justify elimination of the care team. Furthermore, beyond manpower concerns, many anesthesiologists prefer to practice in the care team because of the immediate availability of two providers when there are problems.

The care team involves collaboration by nurse anesthetists and anesthesiologists in concurrent cases. There are distinct requirements in the Medicare regulations which the anesthesiologist must meet in order to be reimbursed for medical direction services. These are important and help to describe the components of the service:

1. perform a pre-anesthesia examination and evaluation;
2. prescribe the anesthesia plan;
3. personally participate in the most demanding procedures in the anesthesia plan, including induction and emergence;
4. ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual;
5. monitors the course of anesthesia administration at frequent intervals;
6. remain physically present and available for immediate diagnosis and treatment of emergencies; and
7. provides indicated post-anesthesia care.

Furthermore, an anesthesiologist engaged in medical direction cannot be personally administering another anesthetic.

For anesthesiologists providing medical direction in concurrent cases, the need to be fully aware of the medical condition and progress of the anesthetic of more than one patient adds responsibilities and risks.

This medical care should and must be appropriately reimbursed.

IMPACT OF THE OMB PROPOSAL

Consider the impact of the cap or single fee proposal under current law and reimbursement rates:

Hernia Repair, 90 minutes:

	1991	1996	1996 with OMB Cap
M.D. alone	$190.00	$139.40	
Team 1:2			
Total	$230.40	$189.60	$139.40
M.D.	$125.40	$ 92.00	$ 41.80
CRNA	$105	$ 97.60	$ 97.60

This assumes: 1) in 1991 the national average conversion factor for anesthesiologists was $19.00; 2) the fully phased-in MFS conversion factor of $13.94 for the physician, and, 3) $9.76 for the nurse. (OBRA '90 sets the reimbursement for medically directed CRNAs at 70 percent of the physician rate; 70% of $13.94 = $9.76.)

The anesthesiologist is left with about $27 per hour per case -- under this example, even three concurrent cases falls short of the payment for one personally administered case. Clearly, only disincentives to care team practice would remain. Even modest redivision of the payment, as we understand the Administration may propose, will not mitigate these drastic reductions. The ASA must state that medical direction services cannot be provided under this scenario.

The Administration makes no recommendations other than to limit payment. Considerations as to employment, access to care, manpower and the viability of this needed anesthesia delivery team must also be addressed when this proposed policy is discussed.

PHYSICIAN PAYMENT REVIEW COMMISSION

The Physician Payment Review Commission (PPRC) studied payments to the anesthesia care team. PPRC stated in its 1991 Report to Congress that "it is not economically viable under current CRNA payment policy to implement a system that pays the same per case regardless of practitioner inputs. Either the CRNA payment at 70 percent of the nonmedically directed level is too high, or team care is not a viable practice arrangement. The Commission believes that supervising anesthesiologists should be paid enough to make it worthwhile to supervise CRNAs, whether as employers of CRNAs or as members of care teams working with hospital-employed CRNAs. CRNAs should also receive a fair payment for their part as care team members." (page 227) If there is to be further study of the anesthesia care team, the PPRC would be the most appropriate body.

MEDICARE FEE SCHEDULE ISSUES

ASA would also like to use this opportunity to comment on two issues contained in the MFS final regulation: anesthesia time and reimbursement for the services of teaching anesthesiologists working with two residents.

This Committee was extremely supportive of ASA efforts to retain the use of actual anesthesia time under the Medicare Fee Schedule. Both legislative history and common sense support the retention of the ASA Relative Value Guide, base units plus time, under the MFS. HCFA, on the other hand, wants to use average anesthesia times. While the input of this Committee was successful in continuing actual time in 1992, HCFA clearly intends to move to average time in the near future. Retention of actual time is budget neutral and consistent with the intent of OBRA '89. We must stress that positive legislative language requiring the use of actual anesthesia time under the MFS is needed to halt HCFA from ignoring OBRA '89, and we ask for your assistance in achieving a permanent solution to this issue.

The MFS regulation also indicates that, in 1994, the reimbursement for anesthesiologists practicing in teaching settings with residents will be changed. Currently, an attending anesthesiologist working with two residents concurrently is reimbursed as if the case were personally performed, i.e., the base and time unit reductions for working with CRNAs are not applied.

The teaching of residents is clearly different from the provision of medical direction. There is a long history of teaching two residents -- this is not a recent development or an attempt to game the system. In fact, it is clearly driven by the need to teach appropriately, not to gain reimbursement, because the profession self-limits to no more than two concurrent residents.

ASA does not believe that changing the rules for anesthesiologists so as to eliminate full reimbursement for two concurrent cases creates a level playing field among teaching physicians. There is overlap among surgeries involving surgical residents and multiplicity of patients in medical settings. It would be extremely disruptive to the provision of care in

academic institutions and to the nearly 5,000 anesthesiology residents currently in the system to reverse the existing payment system. Although HCFA recently proposed changing the reimbursement of academic anesthesia so that medical direction rules would govern cases involving two residents, the final MFS delays such an action for two years. ASA believes the delay should be permanent.

We appreciate the opportunity to appear before the Committee and look forward once again to working with you.

PREPARED STATEMENT OF HOPE S. FOSTER

The American Clinical Laboratory Association ("ACLA") is pleased to have this opportunity to comment on the Administration's Medicare budget proposals affecting reimbursement for clinical laboratory testing. ACLA is a trade association of federally regulated, independent clinical laboratories. ACLA members would, of course, be directly affected by the Administration's proposals.

For many years, ACLA has, on numerous occasions, appeared before this Committee to offer our views-and our cooperation ways to lower the federal deficit through equitable reductions in Medicare outlays for laboratory testing. In 1984, we assisted in the development of the Medicare fee schedule, which substantially reduced the amounts that Medicare paid laboratories. In 1987, 1989, and 1990, we worked with Congress in suggesting other savings that could be achieved through a lowering of the national limitation amounts. In fact, as a result of the budget agreement reached in 1990, a proposal that ACLA supported, clinical laboratories will absorb cuts of $770 million between 1991 and 1996.[1] ACLA has participated in this process because we recognize our responsibility to help reduce the mounting federal deficit.

Now, however, the Administration has suggested still further cuts in laboratory reimbursement. In the recent message budget submitted to Congress, the Administration has proposed reducing the cap on the laboratory fee schedules, from their current level of 88 percent of the fee schedule medians, to 76 percent of the medians. Further, while OBRA'90 limited the CPI update to 2 percent, the Administration recommends limiting the update further, "as needed, to more accurately reflect current market factors."

In view of past cuts suffered by laboratories and rising laboratory costs, ACLA must object to these proposals. ACLA does not wish, however, simply to appear today to say that there should be no changes in laboratory reimbursement. ACLA has repeatedly urged that certain structural changes be instituted in the industry through passage of a federal direct billing law, which would prohibit laboratories from billing physicians for non-Medicare testing. Under current practice, physicians mark-up the laboratory's charge for this testing when billing patients and third-party payors. We understand that Senator Brock Adams plans to introduce a bill requiring direct billing in the near future. When enacted, this legislation will result in a more efficient laboratory market that will ultimately benefit all payoff, including Medicare, by eliminating mark-up and lowering utilization. Indeed, if direct billing becomes a reality, ACLA would be pleased to work with this Committee in determining how additional, equitable reductions in laboratory reimbursement could be achieved. Without the enactment of direct billing, however, the Administration's proposals will injure the quality of laboratory testing that Medicare beneficiaries currently enjoy.

In our testimony today, we would first like to give some background on the history of laboratory reimbursement under Medicare. Then, we will address the Administration's current proposal Finally, we will suggest our own proposal for reform of the laboratory reimbursement system.

I. LABORATORIES HAVE ENDURED CUTS IN REIMBURSEMENT AND RISING COSTS

Laboratory testing is an important, life-saving and cost-containing health care tool, which permits the early detection and treatment of a variety of conditions. Laboratory testing has been instrumental in allowing for the early diagnosis of such re-

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[1] Committee on Ways and Means, *Overview of Entitlement Programs* ("*The Green Book*") at 209 (1991). *See* Appendix I to this testimony for a summary of recent cuts in Medicare laboratory reimbursement.

cently discovered diseases as AIDS and Hepatitis C. Other tests, such as therapeutic drug monitoring ("TDM") assays, are used routinely to track the effects of medications prescribed for cancer and other serious illnesses. Concern about coronary heart disease has caused an increased awareness of the need to perform regular cholesterol testing and related measurements of HDL and LDL.

The early diagnosis and treatment permitted by appropriate testing ultimately saves money for all health care payors, including Medicare. For example, recent reports have indicated that a simple blood test may be more effective in detecting prostate cancer than current methods, thereby permitting earlier treatment and avoiding the need for costly surgery. Indeed, the greatest value of clinical testing is its ability to lead to the early diagnosis of disease and to prompt, cost-effective treatment.[2]

Moreover, laboratory testing is relatively inexpensive today, at least when offered by independent clinical laboratories. For example, the government estimates that in 1992 Medicare will spend only $56.17 per Medicare enrollee for independent laboratory services, as opposed to $1319.41 for physician services, $404.53 for outpatient hospital services and $151.97 for group practice prepayment services. Part B payments for all services are estimated to be $1,934.09 per enrollee.[3] Thus, independent laboratory services account for less than 3 percent of this amount.

Furthermore, since 1984, laboratories, like many provider groups, have repeatedly had to confront reduced reimbursement. The caps on the fee schedules, which were initially set at 115 percent of the fee schedule medians by COBRA'86, were subsequently reduced to 100 percent by OBRA'87; to 93 percent by OBRA'89; and then to 88 percent by OBRA'90. At the same time, there have also been reductions in the CPI updates and freezes on other payments. Medicare reimbursement of laboratory testing is now only a fraction of what it was in 1984 when the fee schedules were first implemented.

Appendix I, which is attached to this testimony, shows the impact of these repeated cuts in reimbursement for clinical laboratory services. The five different budget bills enacted between 1984 and 1990 cut clinical laboratory reimbursement by an estimated $3.5 billion. The Administration's latest budget request would impose almost $4 billion in additional cuts. Such repeated cuts cannot help but have some effect on quality, access and the ability of laboratories to serve rural and low-volume areas.

At the same time, the costs of laboratory testing have increased substantially. For example, as a result of the emergence of AIDS and Hepatitis B, laboratories now take additional precautions to protect workers from bloodborne pathogens, as required by the Occupational Safety and Health Administration, including paying for workers' vaccinations against Hepatitis B. Laboratories do not argue with the need to protect workers from the risks associated with these diseases; however, implementing these precautions is expensive. Other regulations, including those related to medical waste removal and treatment, have added further to laboratory expenditures.

In addition, the laboratory industry is highly labor intensive and salaries for skilled individuals necessary to conduct testing have grown in the past few years. Between 1985 and 1991, the average earnings of an individual employed in the health care field increased by about 38 percent.[4] The number of individuals employed in the laboratory industry over the past five years rose by over 42 percent.[5] Thus, laboratory labor costs have escalated dramatically over the past five years.

New federal workload limitations in the area of cytology will only further increase these costs. For example, ACLA members report that over the past two years, salaries for cytotechnologists alone doubled due to the shortage of qualified individuals. Moreover, the new CLIA regulations, though reportedly not nearly as comprehensive as ACLA had hoped, will still place some additional financial burdens on laboratories.

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[2] Over the paet year and a half, ACLA hae eponsored a eeries of informational breakfasts for Membere of Congreee and etaff on eignificant ieeues related to laboratory testing. Our next breakfast ie scheduled for March 11, 1992 and will addrese the role of laboratory teeting in preventive health care. We hope all Members of the Committee will be able to join us at thie preeentation.

[3] Board of Truetees, Federal Supplementary Medical Insurance Trust Fund, *1991 Annual Report of the Board,* at 43.

[4] See Statistical Abstract of the United States, 1991 at 410; Bureau of Labor Statietice, U.S. Dept. of Labor, Employment and Earnings, December 1991, at 107.

[5] *See Statistical Abstract of the United States,* 1991 at 783; Bureau of Labor Statistics, U.S. Dept. of Labor, *Employment and Earnings,* December 1991 at 61.

Such increasing costs, when coupled with reductions in reimbursement, cannot help but have some effect on the ability of laboratories to offer efficient, high quality laboratory testing to all those who need it.

II. THE ADMINISTRATION'S PLANNED LABORATORY CUTS ARE UNFAIR

Given this history of reductions in reimbursement and increases in costs, ACLA believes that the Administration's current proposal to cut laboratory reimbursement even further is clearly unwarranted. The Administration suggests that its proposals would reduce laboratory payments by $310 million in the first year and almost $4 billion over five years. As noted above, the Administration's current proposal would cut payments by more than the total of all the cuts imposed on laboratories since 1984.

Further, while laboratory expenditures reportedly only amount to about 5 percent of all Part B expenditures, laboratories account for about 72 percent of the Part B provider cuts proposed by the Administration. No other provider group, except for hospitals, is being asked to take as large a dollar cut as clinical laboratories. In view of the cuts in reimbursement that laboratories have suffered over the past eight years, these latest proposals seem clearly unfair and punitive.

Finally, we must also object to the Administration's proposal to further limit the CPI update that laboratories would otherwise receive. As noted above, under OBRA '90, this update was capped at 2 percent until 1994, at which time it was to reflect the full increase in the CPI. The Administration's latest proposal does not even suggest how the current 2 percent update is to be changed. Indeed, ACLA cannot determine whether the update would be more than 2 percent or less, as a result of this proposal. We do not think such vague suggestions can make for good budget policy.

III. CONGRESS SHOULD ADOPT DIRECT BILLING LEGISLATION

ACLA believes that the impetus for the Administration's proposals is a report Issued last year by the General Accounting Office ("GAO") that suggested that laboratories earn more on Medicare testing than on testing provided to physicians for their non-Medicare patients. ACLA members cooperated with the GAO and supplied much of the financial information on which the GAO report is based.

ACLA believes that in a number of respects, however, the GAO failed to properly allocate costs or consider many of the cost increases that are discussed above. Thus, the GAO may have overstated substantially the differences between what laboratories earn on Medicare and non-Medicare testing.

Nonetheless, the GAO has identified a structural problem in the laboratory industry, which ACLA Itself has pointed out in testimony before this Committee. This structural problem occurs because the current market system permits physicians to demand and obtain large discounts from laboratories for non-Medicare testing. Physicians then mark up these discounted prices by a substantial amount when they bill patients and third-party payors for the purchased tests, even though the physician plays a relatively small role in the testing process. In response to this pressure to discount, many laboratories have had to charge third-party payors and patients more than doctors. Medicare, however, still enjoys a substantial discount from the prices paid by these payors.

In short, the GAO's findings demonstrate the following interplay of forces in the laboratory industry. Physicians act as brokers, paying the lowest amount for tests because they control the volume of testing. Physicians then bill third-party payors and patients more than the laboratory charges. Medicare pays the next lowest amount, as the government has protected itself through implementation of the fee schedules and the national limitation amounts. Finally, patients and third-party payors usually pay the most, either because they pay the physician's mark-up or because they bear the higher costs that laboratories are forced to pass on to offset shrinking Medicare revenues and physician discounts.

This structural problem demands a structural solution—implementation of a direct billing mandate that will remove physicians from their role as "brokers" of laboratory testing. Simply reducing Medicare reimbursement, as the Administration proposes, without addressing this basic structural problem, will only make the situation worse, by forcing laboratories to raise prices further where they can-to third-party payors or patients. The real solution to this problem is to remove the physician from his or her pivotal role in the process. Thus, the federal government should do for the private sector what it did long ago for Medicare: require laboratory direct billing to patients and third parties by prohibiting laboratories from billing physicians. This solution will eliminate physician mark-up and the physician-generated price pressure on independent laboratories. Laboratories could then adopt a more

rational pricing system that would benefit third-party payors, patients and Medicare.

ACLA has recently been informed that Senator Brock Adams has drafted legislation that would require direct billing for laboratory services. We have also been informed that he plans to introduce this legislation sometime within the next several weeks.

ACLA obviously believes that this legislation, rather than simply cutting the fee schedules one more time, is the appropriate and rational way of reforming clinical laboratory reimbursement. We hope that all members of this Committee will join ACLA In supporting this legislation. Moreover, because such legislation would, ACLA believes, establish a more rational competitive environment, direct billing will permit laboratories to absorb some reductions in the amounts that Medicare pays.

IV. CONCLUSION

ACLA is anxious to participate with the Administration and the Committee in addressing concerns about clinical laboratory reimbursement. We believe, however, that it is important to find long-term solutions, not just easy answers. Wholesale slashing of the Medicare fee schedule is not appropriate, because it will only exacerbate the problems that exist today. Federal implementation of a direct billing mandate, coupled with appropriate reductions in the Medicare fee schedules, is the most reasonable and equitable way of dealing with these concerns. We look forward to working with you to achieve these goals.

EXPECTED SAVINGS FROM LABORATORY CUTS (In millions)

	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	TOTALS
						(FISCAL YEAR)									
DEFRA '84 1/ (established lab fee schedule)	40	240	300	380											960
COBRA '86 (established fee caps at 115% of the medians) 2/			10	12	22	22	27	37							130
OBRA '87 (3 month freeze on fee schedules; reduction of caps to 100%; reduction in fees for automated tests; limited CPI update) 3/					65	135	225								425
OBRA '89 (reduction in caps to 93%) 4/							85	130	155	185	215				770
OBRA '90 (reduction in caps to 88%; limited CPI update) 5/								90	185	270	325	365			1,235
ADMINISTRATION PROPOSALS (reduce caps to 76% and limit CPI update) 6/										310	560	770	1,020	1,320	3,980
TOTAL	40	240	310	392	87	157	337	257	340	765	1,100	1,135	1,020	1,320	7,500

1/ Background Material and Data on Programs Within The Jurisdiction Of The Committee on Ways and Means at 161 (1986).

2/ Background Material and Data on Programs Within The Jurisdiction Of The Committee on Ways and Means at 169 (1987).

3/ Background Material and Data on Programs Within The Jurisdiction Of The Committee on Ways and Means at 184 (1989).

4/ 1991 Green Book at 209 (1991).

5/ Id. at 230 (1991).

6/ Budget of the United States Fiscal Year 1993, at 26 (1992).

Prepared Statement of Scott Gray

My name is Scott Gray. I am an independent contractor and chief CRNA at Grays Harbor Community Hospital in Aberdeen, Washington. As the current President of the American Association of Nurse Anesthetists (AANA), I want to convey to the members of this committee our appreciation for the support that you have repeatedly shown for certified registered nurse anesthetists (CRNAs). We understand that you have had to make tough choices on anesthesia payment issues in the past, and will continue to have to confront federal budget deficits in the future.

The AANA is pleased to have the opportunity to testify on President Bush's budget proposal on anesthesia services. Our testimony will also very briefly address three related Medicare anesthesia issues that we know are of great interest to the committee: the 70 percent payment relationship between medically directed and nonmedically directed CRNAs that was inherent in the Omnibus Budget Reconciliation Act of 1990 (OBRA90), the retention of actual time for calculating anesthesia payments, and payment for the supervision of anesthesiology residents and nurse anesthesia students.

President's Budget Proposal on Anesthesia Services

As the professional society that represents over 24,000 CRNAs, which is 96 percent of all nurse anesthetists who practice across the United States, we do not support the president's budget proposal on anesthesia services. The president's budget advocates a Medicare legislative initiative that would set a single fee for anesthesia services, regardless of whether an anesthesiologist personally performs the service or medically directs a CRNA. This overly simplistic approach to a very complicated issue has been included in the president's budget proposals for the last several years as a way to cut Medicare spending. Each year, this approach has been rejected by this committee. We strongly encourage you to reject it again.

We believe that any additional changes in Medicare reimbursement policy for anesthesia services should be undertaken with great caution for the following reasons:

1. The Health Care Financing Administration (HCFA) final rule on the Medicare physician fee schedule under the resource-based relative value scale (RBRVS) system has had a major impact on the current system of payment for anesthesia services. In light of the dramatic 27-29 percent cut in anesthesia services under the new RBRVS system, we do not believe that this is the time to approve additional cuts in anesthesia of $100 million in 1993 and $920 million over five years.

   The anesthesia payment changes that went into effect just last month should be analyzed before any additional recommendations for changes in Medicare reimbursement policy for anesthesia services are adopted by Congress.

2. The AANA believes that reform of the current health care system is necessary. We believe that every American should have access to quality, cost-effective health care, including anesthesia services. CRNAs currently provide over 65 percent of all anesthetics administered in the United States annually, according to a 1988 Center for Health Economics Research study. CRNAs are the sole anesthesia providers in 85 percent of rural hospitals, affording these medical facilities obstetrical, surgical, and trauma stabilization capability. Consequently, we would be concerned about any change in

payment policy that could result in fewer CRNAs being available to provide anesthesia, which could further restrict access to health care, especially in rural areas.

3. Depending on the payment methodology used to implement the president's budget proposal, severe disruption to the current anesthesia delivery system could occur. Further Medicare payment reductions could result in employment shifts for CRNAs. Currently 75 percent of CRNAs are medically directed and work in a variety of practice settings. Based on 1991 AANA membership survey data, about 35 percent of our members are employed by CRNA/anesthesiology groups, about 40 percent are employed by hospitals, about 15 percent are self-employed or work in CRNA groups, and the remaining 10 percent work in other settings, including the military or Veterans Administration facilities.

   In situations where the CRNA administering the anesthetic is employed by a hospital, and the anesthesiologist providing medical direction is a member of a contracting private anesthesiology group, consideration would need to be given to continuing to write two separate Medicare checks for the anesthesia service. One check would need to be written to the hospital in payment for the CRNA service and one check would need to be written to the private anesthesiology group in payment for the anesthesiologist service. While the total of the two checks would not exceed the Medicare RBRVS payment that would be made if a solo anesthesiologist provided the service, writing two checks would be necessary to eliminate the battle over control of the monies that might result if only one check were written - either to the hospital or to the private anesthesiology group.

4. There is not always an equal opportunity to compete. For example, it is sometimes difficult for CRNAs to secure hospital/facility clinical privileges due to a variety of factors. These factors include exclusive contracts and restrictive medical staff bylaws which either prohibit or deter applications based on the class of the provider, or require recommendation and/or approval by the Physician Chief of the Anesthesiology Department. These factors are often difficult to surmount because CRNAs with hospital/facility clinical privileges may be viewed as competitors of the anesthesiologists on staff at the hospital. Consequently, federal law would need to be amended to require that institutions receiving Medicare payment not discriminate against providers as a class in the awarding of hospital/facility clinical privileges.

5. The AANA does not endorse one type of anesthesia practice arrangement over another. The association has historically believed that the marketplace should decide what CRNA/anesthesiologist practice arrangements should be. CRNAs may choose whether to work under medical direction, or not, as they see fit. Some CRNAs view their nonmedically directed services as being the most cost-effective way of providing anesthesia care. Others choose to work under the medical direction of an anesthesiologist because of the particular hospital or medical staff philosophies.

6. In February 1990, the Department of Health and Human Services released a report entitled, "Study of Nurse Anesthetist Manpower Needs". The report presents the results of a study by Health Economics Research that projected an increase of 70 percent for total surgical procedures between 1985 and 2010 in the United States. The study also forecast that total anesthetics will grow by over 13.7 million between 1985 and 2010, or 62 percent. At the same time, the study reported a

shortage of 6,000 CRNAs for 1990, or a 13.6 percent shortfall. It further reported the need for 30,000 CRNAs by the year 2000, and over 35,000 CRNAs by the year 2010.

To meet this need for CRNAs, the educational system for nurse anesthetists will have to graduate 1,800 students yearly between now and the year 2000, and 1,500 graduates per year thereafter. The loss of nurse anesthesia educational programs since 1984, however, has resulted in a decrease in the number of graduates from approximately 1,100 to 650 nurse anesthesia graduates in 1990. The decrease in graduates is not, however, related to a decreased pool of applicants. Data indicates that there are three qualified applicants for every available student vacancy in a nurse anesthesia program.

There is a clear need for additional nurse anesthesia educational programs to educate more CRNAs for the following reasons:

a. The current severe shortage of CRNAs, especially in rural America where CRNAs are the predominant anesthesia providers.

b. The projected escalating need for CRNAs as previously identified.

c. Although an increasing number of anesthesiologists are being prepared due to current Medicare financial incentives, there is no data to indicate that they are moving into rural areas to provide anesthesia care.

d. We believe that there is sufficient justification to warrant educating more CRNAs than anesthesiologists based on costs to society for both their education and level of payment for services.

Therefore, we believe that any future change to the Medicare payment methodology should have a neutral effect relative to the preparation of anesthesiology residents and nurse anesthesia students. There should be equitable treatment in terms of payment for the supervision of anesthesiology residents and nurse anesthesia students by anesthesiologists and/or CRNAs. Both anesthesiologists and CRNAs should be reimbursed for providing an anesthesia service and a clinical instruction service when supervising anesthesia trainees.

<u>Other Issues Related to Anesthesia Payment Limitation Discussion</u>

The AANA believes that if the committee at some future point does consider limiting payment for an anesthesia service to the payment made to a solo anesthesiologist for the same service, the following changes would also need to be made concomitantly:

1. Eliminate the current Medicare seven conditions of participation which an anesthesiologist must fulfill in order to be reimbursed for medical direction of CRNAs. Pursuant to the Tax Equity and Fiscal Responsibility Act of 1982, current Medicare carrier manual instructions state that in order to be paid for medical direction of a CRNA, the anesthesiologist must meet the following seven conditions of participation:

   a. performs a pre-anesthesia examination and evaluation;

   b. prescribes the anesthesia plan;

   c. personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;

d. ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual;

e. monitors the course of anesthesia administration at frequent intervals;

f. remains physically present and available for immediate diagnosis and treatment of emergencies; and

g. provides indicated post-anesthesia care.

We also want to stress that the seven conditions of participation for medical direction payment are purely criteria for payment, not standards of practice or standards of quality. The March 2, 1983 Federal Register at page 8928 specifically addressed this point by stating "Anesthesia administered by a non-physician anesthetist is a covered service reimbursable on a related cost basis whenever it is not included in reimbursement for a physician's service on a charge basis. Therefore, the criteria for 'medical direction' should not be interpreted as standards of practice or standards of quality, but rather as a description of those elements of common medical practice that are expected to be present when a physician has significant involvement with an individual patient." Unfortunately, in spite of the Federal Register clarification, the medical direction criteria have often been erroneously used as practice or quality standards.

2. Eliminate the current Medicare restriction that anesthesiologists will be paid for medically directing no more than four CRNAs concurrently.

3. Eliminate the 10/25/40 percent reduction in base units and use of 30 minute time units for Medicare payment in cases where the anesthesiologist medically directs two or more CRNAs.

4. Restrict institutions receiving Medicare payments from discriminating against CRNAs, as a class, in the awarding of hospital/facility clinical privileges.

5. Provide equitable treatment in terms of payment for the supervision of anesthesiology residents and nurse anesthesia students by anesthesiologists and/or CRNAs. Both anesthesiologists and CRNAs should be reimbursed for providing an anesthesia service and a clinical instruction service when supervising anesthesia trainees.

6. Maintain a mechanism whereby payment can be made for the services of two anesthesia providers on a single case.

7. Provide a mechanism to be able to write two separate checks in the situation where a hospital-employed CRNA administers an anesthetic and a private anesthesiology group contracts with the hospital to medically direct the hospital-employed CRNA. The total of the two checks could not exceed the RBRVS amount that would be paid if a solo anesthesiologist provided the anesthesia service.

Relationship between Medicare Payment for Medically Directed and Nonmedically Directed CRNAs

The intent behind the OBRA90 provision that increased CRNA Medicare conversion factors (CFs) was to phase in a higher CRNA fee schedule over a six year period, knowing that the fee schedule for anesthesiologists would be reduced over the 1992-1996 transition

period for RBRVS. Congress was willing to ultimately reimburse nonmedically directed CRNA services at the same level as anesthesiologists, but wanted the nonmedically directed CRNA to not be at the same CF as an anesthesiologist until 1996.

Because anesthesiology services in 1990 were estimated to be, on average, 82 percent overvalued, it was determined that the CF for anesthesiology services in 1996 should be approximately 82 percent of the 1990 weighted national average conversion factor for these services. With an average CF of $20.42 in 1990, it was calculated that this would produce an ultimate anesthesiology CF of $16.75 in 1996. Consequently, the nonmedically directed CRNA rate was legislated to begin in 1991 at $15.50 and increase by $0.25 each year until it reached $16.75 in 1996 (subject to geographic factors). It was agreed that the medically directed CRNA CF should be set at approximately 70 percent of the nonmedically directed CRNA CF. Therefore, the new CF for medically directed CRNAs was legislated to begin in 1991 at $10.50 and increase by approximately $0.25 each year until it reached $11.70 in 1996 (subject to geographic adjustments).

However, the services of anesthesiologists were ultimately determined to be 27-29 percent overvalued. Therefore, beginning in 1992, the CRNA CFs mandated by OBRA90 were higher in relation to anesthesiologist CFs than had originally been expected. This situation was not a problem for nonmedically directed CRNAs because a provision in OBRA90 limited their CF in a locality to the anesthesiologist CF in that same locality. Consequently, nonmedically directed CRNAs were not making more than an anesthesiologist in that same locality.

A concern did arise, however, about the fact that there was no provision in OBRA90 specifically limiting medically directed CRNA CFs to 70 percent of the nonmedically directed CRNA CFs. As a result, in some localities, the 1992 medically directed CRNA CFs are higher than 70 percent of the nonmedically directed CRNA CFs. HCFA did not modify the CFs for medically directed CRNAs in 1992.

As the RBRVS transition continues to decrease the CFs for anesthesiologists, nonmedically CRNAs will continue to be capped at the anesthesiologist CF. This means that medically directed CRNA CFs will continue to increase in some localities above 70 percent of the nonmedically directed CRNA CFs, as had been the legislative intent in OBRA90.

The implementation of the anesthesiologist CFs under RBRVS has had an unexpected impact on the CRNA CFs established in OBRA90. The AANA realizes that an issue has arisen regarding the legislative intent to have the CFs for a medically directed CRNA be at 70 percent of the CFs for a nonmedically directed CRNA established under OBRA90. We are studying the issue and look forward to working with the committee to address the situation.

Retention of Actual Time for Calculating Anesthesia Payments

We also want to take the opportunity to encourage the committee to adopt legislation or bill report language clarifying the congressional intent to retain the use of actual time in calculating payment for anesthesia services. While temporarily retaining the use of actual time in the November 25, 1991 final rule on physician payment, HCFA indicated that it will be analyzing how to pay differently for anesthesia time in the future.

The AANA has consistently opposed the outright elimination of the use of time units in the calculation of anesthesia payments for numerous reasons. Unlike HCFA, we believe that Congress has repeatedly expressed its clear intent to continue to use time

units. This was indicated in the Omnibus Budget Reconciliation Act of 1987 (OBRA87) which mandated the adoption of the uniform relative value guide for use by all Medicare carriers when reimbursing for anesthesia services. In the Omnibus Budget Reconciliation Act of 1989 (OBRA89), Congress modified the use of time units to require that actual minutes be counted in fractional time units. The key point is that Congress did not statutorily eliminate time units in either OBRA87 or OBRA89, when you were directly addressing the time issue.

Although we have disagreed with HCFA on the elimination of time units, we have worked with them to remedy their concern about problems with billing for preoperative time. Both the AANA and the American Society of Anesthesiologists worked closely with HCFA on developing a new, tighter definition of time. A new time definition was, in fact, included in the November 25, 1991 physician payment rule. We believe that this clarification of the definition of anesthesia time obviates the need to develop an alternative payment methodology for anesthesia time.

However, in light of HCFA's continued zeal to eliminate the use of actual anesthesia time, we strongly urge Congress to send HCFA a very clear legislative message that the use of actual anesthesia time should be retained permanently.

Payment for the Supervision of Anesthesiology Residents and Nurse Anesthesia Students

There are two issues regarding anesthesiology residents and nurse anesthesia students that we would like to mention.

1. Teaching Anesthesiologists and Anesthesiology Residents

Currently, teaching anesthesiologists are routinely paid full base and time units when involved with two concurrent cases involving anesthesiology residents. It is also current policy that when an anesthesiologist medically directs two CRNAs, the anesthesiologist's base units in each case are reduced by 10 percent and 30-minute time units are used rather than 15-minute time units. In contrast, the lack of an official HCFA policy on payment for teaching anesthesiologist or CRNA direction of student nurse anesthetists has led Medicare carriers to uniformly deny payment for the concurrent direction by a teaching anesthesiologist or CRNA of up to two student nurse anesthetists.

In the November 25, 1991 physician payment rule, HCFA modified its policy on the Medicare payment of teaching anesthesiologists when working with anesthesiology residents. HCFA stated that it intends to remedy the disparity in payments between concurrent procedures involving residents and "other nonphysician anesthetists." However, to give teaching hospitals time to adjust their practices, HCFA will continue the policy that allows full payments for two concurrent cases involving anesthesiology residents through December 31, 1993. For services furnished after that date, full base and time units will be paid only if the teaching anesthesiologist establishes an "attending physician" relationship in a single case involving a resident. Beginning on January 1, 1994, HCFA will apply the current medical direction payment policy to two concurrent procedures involving anesthesiology residents, i.e., the base units in each case are reduced by 10 percent and 30-minute time units are used rather than 15-minute time units. With this change, there will be equity in Medicare payment between anesthesiology residents and other nonphysician anesthetists.

The AANA is pleased that HCFA has agreed to remedy the disparity in payments between anesthesiology residents and other nonphysician

anesthetists. However, we believe that equity demands that the new HCFA payment policy regarding anesthesiology residents become effective immediately, rather than being delayed until 1994.

2. CRNAs and Nurse Anesthesia Students

A situation involving CRNAs and student nurse anesthetists still needs to be addressed. Currently CRNAs are not reimbursed for supervising two nurse anesthesia students. It is our understanding that this policy will not be included in HCFA's final payment rule for CRNAs. (HCFA's January 1989 proposed CRNA payment rule still has not been issued as a final rule). If the CRNA final payment rule does not remedy this inequity regarding payment for CRNAs supervising two nurse anesthesia students, we may need to approach this committee for legislative assistance in this matter.

Summary

First, we strongly urge you to reject the president's overly simplistic budget proposal on anesthesia services. If the committee in the future does consider limiting payment for an anesthesia service to the payment made to a solo anesthesiologist for the same service, numerous other policy changes would need to be made concomitantly. Second, the AANA realizes that an issue has arisen regarding the legislative intent to have the CFs for a medically directed CRNA be at 70 percent of the CFs for a nonmedically directed CRNA established under OBRA90. We are studying the issue and look forward to working with the committee to address the situation. Third, in light of HCFA's continued zeal to eliminate the use of actual anesthesia time, we urge Congress to send HCFA a very clear legislative message that the use of actual anesthesia time should be retained permanently. Fourth, the AANA is pleased that HCFA has agreed to remedy the disparity in payments between anesthesiology residents and other nonphysician anesthetists. However, we believe that equity demands that the new HCFA payment policy regarding anesthesiology residents become effective immediately, rather than being delayed until 1994.

Thank you for the opportunity to present our views on these issues.

Prepared Statement of Senator Herb Kohl

Mr. Chairman and distinguished members of the Committee, I thank you for this opportunity to testify. You already have a abundance of options before you, and I admire your courage in soliciting more from your colleagues.

I understand that today's hearing is not about the general direction that tax legislation should take. However, I would like to spend one minute outlining my views; they provide the context for the specific proposals I am here to support.

I believe that tax legislation passed by the Congress this year ought to have three, related goals. First, it ought to change the tax code to encourage long-term growth. That means adopting investment and savings incentives, but, perhaps more importantly, it means doing so in a deficit-neutral manner. There is no greater drag on this country's growth and prosperity than the enormous Federal deficit and debts we have accumulated.

Second, this year's tax bill ought to begin to repair the deteriorating progressivity of the code. And third, the bill should provide some relief to the workers and families who are the innocent victims of the current, lingering recession.

The first measure I would like to bring to the Committee's attention today is related to this third goal. S. 693, introduced by Senator Lautenberg and myself last March, would amend the Internal Revenue Code to exempt individuals who are involuntarily unemployed from the 10 percent surtax on early distributions from qualified pension plans and IRAs. I would ask that the Chairman include the text of S. 693 as part of today's hearing record.

This bill makes sense in both economic and human terms. Workers, who are forced out of their Jobs by lay-offs or plant closings may lose their houses, take their children out of college, forfeit their cars, or severely cut back on their purchases of basic goods and services—even though they have substantial savings in their retirement plans. The current penalties on withdrawing those savings needlessly intensify the decline in general economic activity experienced during a recession and the personal pain that a family endures when one of their bread winners becomes unemployed.

Unfortunately, in the State of Wisconsin, this issues goes far beyond economic theory. The problem that S. 693 addresses was brought to my attention by an announcement last year that Uniroyal would shut down their Eau Claire tire production facility. Close to 1400 Wisconsinites will lose their jobs in this plant closing.

The company has informed its employees that, when they are let go, they may discontinue retirement savings and use a termination allowance to meet current living expenses. However, if an employees chooses to take the immediate termination benefit, it will be subject to a 10 percent Federal penalty and a State of Wisconsin surtax equal to 33 percent of the Federal penalty.

Approximately 890 employees involved in the Uniroyal closing have accumulated savings that they cannot access without having to pay these Federal and State penalties. These are employees with years of service, with families to support, with mortgages, with the bills and obligations we all face. Many will have no choice but to take the termination allowance. Who is served when the Federal government and the State government also take a large chunk of the money that these workers need to keep themselves and their families going?

The workers in Eau Claire are, unfortunately, not unique. Plant closings and lay-offs have forced mature and skilled workers across the nation into a financial strangle-hold. S. 693 could help loosen that.

I would like to add that, for all the good S. 693 will do, it costs very little; its annual cost is under $50 million. I ask that a cost estimate prepared by the Joint Tax Committee be included in the record at this point. Also, S. 693 fits in well with the legislation the Chairman has introduced to make retirement savings in IRAs more flexible—a bill I support fully and have cosponsored.

The second set of proposals I would like to discuss with you relate to growth. First, I encourage the Committee to adopt in full Senator Bumpers targeted capital gains proposal, S. 1932. This bill allows tax breaks only for investments in the small, start up businesses that—even in the face of a disappearing pool of venture capital—have led growth and job production in this country.

Second, I would urge the Committee to reject any proposal that would increase the depreciation period for computer software. This country is a global leader in the production of computer software products. It makes no sense to cripple this lead by imposing on software products a unrealistically long tax life.

And third, I would like to add my voice to the many calling for the repeal of the luxury tax on boats. What a mistake that was. Instead of taxing the rich, we struck a direct blow to an industry that provides high-quality, American jobs. In Wisconsin alone, at least 3000 jobs disappeared because of this tax. Across the nation, the job loss toll has surpassed 25,000. We don't need to spend any more time talking about this measure; we need to repeal it. I urge you to join our colleagues in the House and report out a repeal of the luxury tax on boats.

Finally, I would like to make several modest proposals that may further the Committee's efforts to make the tax code more supportive of middle income families. Currently, the tax code allows taxpayers to deduct the interest on certain U.S. savings bonds if those bonds are redeemed to cover the educational expenses of the taxpayer, his or her spouse, or his or her dependents. The program is targeted to middle and lower income taxpayers, and bond purchasers must be at least 24 years old to participate.

I have heard complaints from grandparents, friends, godparents, and parents under the age of 24 want to participate in this program but are kept from doing so because of its rules. I understand that the rules are in place to stop use of the tax incentive by those with incomes over the threshold. However, I plan to introduce legislation this week that I believe removes the restrictions and preserves the middle income focus of the program. I hope the Committee will allow me to forward that legislation to you for consideration this year.

I would also like to urge the Committee to pursue simplification of the Earned Income Tax Credit (EITC). Last year, I held a hearing on the new form that EITC recipients will have to fill out. Frankly, it's a mess, and that's not entirely the IRS's fault. Congress added two new credits to the basic EITC in 1990—the Supplemental Young Child Credit and the Supplemental Health Insurance Credit. While the motives that moved these additions was good, the extra information required to grant

them has turned the EITC into an administrative nightmare. It is my concern that, in our attempt to expand the EITC, we may have created a paperwork burden that will result in fewer eligible recipients receiving the credit.

I would ask that the Committee look at two simplification options. At the very least, the Committee should repeal the complicated rules that tie eligibility for the two supplemental credits to other parts of the tax code. In my opinion, an even better option would be to repeal the two credits all together and add the saved revenue to the basic credit.

It is my understanding that the Ways and Means Committee has chosen do this for the Supplemental Young Child Credit only. That is certainly a step in the right direction. However, if the Committee also chooses to go this route, I would suggest repealing the interaction rules that would continue to apply to the Supplemental Health Credit as well.

The EITC is the most powerful tax encouragement provided to lower income, working families. The Committee has a chance this year to see that overly complicated rules don't diminish the potency of this progressive provision.

Thank you sincerely for allowing me the opportunity to discuss these proposals today. Though I would like to see the proposals I discussed included in your final bill, I don't envy the decisions you have to make in the next few weeks. However, as difficult as these may be, I, and the American people can take comfort in the reputation that this Committee has for choosing the course that is right—rather than expedient, political, or popular.

PREPARED STATEMENT OF SENATOR FRANK R. LAUTENBERG

Mr. Chairman and members of this distinguished committee, thank you very much for the opportunity to testify today.

Mr. Chairman, as you know all too well, our nation faces an economic crisis. Almost 9 million people are unemployed and actively looking for work. Of these, over 1.6 million have been jobless for more than 6 months. Meanwhile, those with jobs increasingly are looking over their own shoulder, never knowing when the axe will fall.

Mr. Chairman, nobody in this Congress has done more than you to address the problem of unemployment, and to improve the economic health of our nation. You deserve enormous credit for your leadership in securing the extension of unemployment compensation benefits. You also deserve the thanks of all Americans for your work to increase savings through the "Super I bill, which I have cosponsored, and for your efforts to address the unfair tax burden of the middle class.

Mr. Chairman, I know I don't have to tell you about the severe consequences of unemployment, for the jobless themselves, and for the nation as a whole. Studies indicate that unemployed people have more family and medical problems. They commit more crimes. And they have higher rates of suicide.

Compounding matters, the unemployed face a Catch-22. The longer they're out of work, the less attractive they become to prospective employers. It's a vicious cycle that's very hard to escape.

Mr. Chairman, the long-term unemployed need a helping hand to break out of that cycle.

I, with Senators Riegle and Boren, have introduced legislation, S. 2220, designed to provide that helping hand.

The bill is very simple, and builds on a well-established, existing program, the targeted jobs tax credit, or TJTC.

Under current law, the TJTC is available to employers who hire from among nine targeted groups. These include economically disadvantaged youth, Vietnam-era veterans, ex-convicts, vocational rehabilitation participants, and AFDC recipients. The credit generally is calculated by taking 40 percent of the first $6000 of qualifying first year wages.

Our legislation includes the long-term unemployed as a new targeted group for a period of one year. Under the proposal, employers who hire people who have been receiving unemployment compensation for at least 6 months will get the same benefits as those who hire ex-convicts or welfare recipients. We also suggest a few special rules that would apply in the case of the long-term unemployed, such as establishing a wage cap. That will limit costs and ensure that taxpayers are not subsidizing the hiring of highly-paid executives.

Mr. Chairman, encouraging employment of the long-term unemployed is a matter of basic compassion. But it's also good economic and social policy.

The long-term unemployed represent what might be considered wasted "human capital"—resources that should be contributing to economic growth, but are not.

Putting these people back to work, and increasing their spending power, should help stimulate the economy to the benefit of all Americans.

Moreover, the long-term unemployed impose real costs on working Americans. When the unemployed stop paying taxes, those in the workforce must make up the difference. And as joblessness increases, working Americans also bear greater burdens in paying for AFDC, food stamps and other social support programs. In fact, according to the Congressional Budget Office, for every one percent increase in unemployment beginning this January, the FY93 deficit will increase by $50 billion.

Of course, beyond any economic benefits, reducing long-term unemployment should reduce the many social problems associated with long-term joblessness. As I suggested earlier, these problems range from increased demands on medical institutions, to spousal and child abuse, and other violent crimes.

Mr. Chairman, I won't suggest that this proposal is the cure-all to the problem of long-term unemployment. However, it does have significant advantages.

First, it can produce results quickly. It's simple. It's based on an established program. It doesn't require a lot of planning or new regulations. And it can be understood by beneficiaries and businesses without a great deal of education and assistance.

Second, the bill would not require the creation of an enlarged government bureaucracy. That means greater efficiency and lower costs to taxpayers. It also ensures that we will not be stuck with an entrenched government structure of limited usefulness once the economy turns around.

Third, the bill is well targeted. It helps those who have tried to help themselves. By limiting the legislation to those who have been receiving unemployment compensation, we ensure that those who are assisted are persons who were laid off against their will, and have been actively seeking employment.

Fourth, the bill proposes a temporary solution to deal with what we all expect will be a temporary problem. It will not create a permanent drain on the Federal Treasury. In fact, by pulling the long-term unemployed into the labor force, the legislation may well generate additional revenues for federal, state and local governments well into the future.

Fifth, the bill proposes to reduce long-term unemployment directly. We have heard many proposals recently that would encourage people to do various things, and that would give special breaks to a variety of groups. Proponents generally argue that each break will indirectly trigger a chain of events that eventually results in reduced unemployment. In many cases, that may be true. But if our real goal is to reduce long-term unemployment, why not address the problem head-on? The more direct our approach, the more confident we can be that it will work, and work quickly.

Finally, I am hopeful that this proposal can avoid the intense partisan wrangling that has frustrated progress on so many economically-related proposals. The TJTC is supported by President Bush and enjoys strong, bipartisan support in both houses of Congress.

Before I close, Mr. Chairman, I just want to mention another bill I introduced with Senator Kohl and several other cosponsors, S. 693, that would allow unemployed individuals to make penalty-free withdrawals from their IRA's and other retirement plans. I testified about that legislation last July and I will not repeat what I said then. But, while reducing long-term unemployment may be a higher priority, I hope the Committee will take a look at that proposal as well, which would help the unemployed make ends meet while they look for work.

Again, Mr. Chairman, I want to thank you for the opportunity to appear before you today. I appreciate it, and would be happy to answer any questions you may have.

102D CONGRESS
1ST SESSION

S. 693

To amend the Internal Revenue Code of 1986 to allow individuals who are involuntarily unemployed to withdraw funds from individual retirement accounts and other qualified retirement plans without incurring a tax penalty.

IN THE SENATE OF THE UNITED STATES

MARCH 19 (legislative day, FEBRUARY 6), 1991

Mr. LAUTENBERG (for himself, Mr. KOHL, Mr. BINGAMAN, Mr. INOUYE, and Mr. KERRY) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend the Internal Revenue Code of 1986 to allow individuals who are involuntarily unemployed to withdraw funds from individual retirement accounts and other qualified retirement plans without incurring a tax penalty.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. WAIVER OF EARLY DISTRIBUTION PENALTY DURING PERIODS OF INVOLUNTARY UNEMPLOYMENT.

(a) IN GENERAL.—Paragraph (2) of section 72(t) of the Internal Revenue Code of 1986 (relating to exceptions

to 10-percent additional tax on early distributions from qualified plans) is amended by adding at the end thereof the following new subparagraph:

"(D) DISTRIBUTIONS FOR PERSONS WHO ARE INVOLUNTARILY UNEMPLOYED.—Any distributions which are made during any applicable involuntary unemployment period. For purposes of this subparagraph—

"(i) the term 'applicable involuntary unemployment period' means the consecutive period beginning on the 30th day after the first date on which an individual is entitled to receive unemployment compensation and ending with the date on which the individual begins employment which disqualifies the individual from receiving such compensation (or would disqualify if such compensation had not expired by reason of a limitation on the number of weeks of compensation); and

"(ii) the term 'unemployment compensation' has the meaning given such term by section 85(b)."

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to distributions made after the date of the enactment of this Act.

Prepared Statement of Joe Liu

Mr. Chairman and Members of the Finance Committee:

The Children's Defense Fund (CDF) appreciates this opportunity to testify today regarding the President's proposed Medicaid spending reductions. Although the abstractions of Washington, D.C. can often cause one to forget the real world, America's children depend on this Committee for many of life's basics -- none more important than health care. The decisions you make regarding the future of Medicaid will affect 12 million children and approximately one million pregnant women this year alone. For these women and children, Medicaid is virtually all that stands between them and a complete lack of health insurance coverage. We know that this Committee will continue its long record of leadership on their behalf.

Overview of the President's Reform Plan

In his recently issued national health reform plan, the President suggests paying for the $100 million in proposed new health tax credits and deductions over the next five years in several ways. Many, such as leading healthier lifestyles, medical practice changes in response to curbs in malpractice awards, and tougher, more effective bargaining for employee health coverage by private firms, are good ideas that we support. But from a federal budget point of view, they are speculative. In the context of the budget act's new spending requirements, the proposals yield none of the countable offsets required under the law in order to consider new entitlement legislation or tax expenditures.

Two of the President's proposed sources of financing are not speculative, however. The President's proposed Medicare and Medicaid spending cuts are offered as the only two actual expenditure offsets. Moreover, the fact that they have been proffered in the context of an initiative originally meant to be part of his Fiscal 1993 budget plan means that they must be taken particularly seriously. Whatever happens with national health reform this year, it is possible that these spending reductions could well move ahead.

Impact of the Medicaid Cap on Women and Children

Essentially the President has repackaged in a more attractive box the same cap on Medicaid that was proposed by President Reagan and rejected by Congress 11 years ago. It was dismissed as poor policy then, and it absolutely must be rejected now. The proposal to cap "acute" Medicaid expenditures for the "non-elderly" is nothing less than a direct attack on the portion of the program comprised almost exclusively of women of childbearing age and children -- the poorest, least expensive and most vulnerable beneficiaries. Tax credits and insurance vouchers for the uninsured, whether of any benefit at all, lose all value if purchased at the expense of the nation's poorest women, infants and children.

The proposal to cut Medicaid in order to achieve expanded health coverage is particularly egregious, since no group of Americans stands to benefit more from national health reform than children. In 1990, as Table 1 shows, only slightly more than 60 percent of all American children had access to employer-based health insurance, the primary means of insuring the nation's non-elderly population. Between the summer of 1990 and Election Day, 1992, nearly 20 million children -- approximately 43 percent of the 46 million privately insured children will go for some period without coverage. Over the 1977-1987 time period, as shown on Table 2, the proportion of children with employer coverage declined by 13.6 percent, from 72.8 to 62.9 percent. At this rate of decline, by the end of the decade, without major reforms, the proportion of U.S. children with employer-insurance will stand at

50 percent overall: a one-in-two chance of coverage under America's "mainstream" form of health insurance for the non-elderly.

As the employer system disintegrates for minor dependents, Medicaid's role, for better or worse, grows ever more prominent. Had there been no Medicaid, the number of completely uninsured children in 1990 would have stood at more than 18 million rather than 8.4 million -- 28 percent of the under-18 child population rather than 13 percent. Whether for children who are losing their private coverage or for those who never had it to begin with, Medicaid is a health insurance lifeline -- sometimes too slender, to be sure, but a lifeline nonetheless.

As employer coverage has grown increasingly fragile for children, their dependence on Medicaid has grown. Medicaid now finances between 30 and 40 percent of all births in most states; in a few, the proportion of Medicaid-financed births is reportedly nearing 50 percent of all births. One in three children under age 6 in the U.S. is now potentially eligible for Medicaid, given children's very high poverty rates and the program's recent and vital eligibility expansions. Medicaid is now a primary source of financing for a broad range of pediatric health care, from immunizations to specialized hospital care for sick and disabled children.

Despite the enormous role Medicaid has assumed for children in the absence of a national child health policy, the President proposes to significantly reduce program outlays for women and children. He would accomplish this by setting state-by-state per-capita limits on "acute" health expenditures for the non-elderly (long-term care and expenditures for persons over age 65 would be exempt from these growth limits). Potentially included in the list of "acute" health care services for the non-elderly are prenatal care, hospital and medical care for sick newborn infants, immunizations, checkups, physician and clinic visits, eyeglasses, dental care, and hearing aids for children, community-based services for infants and toddlers with developmental disabilities, and many more essential health services far too numerous to mention.

In other words, under the guise of "acute care for the non elderly" is buried virtually the entire portion of the Medicaid program devoted to women and children. This is already the smallest part of the program with the least amount of growth. The only truly significant spending growth occurring in this population is major caseload increases resulting from increased poverty and eligibility expansions. Fortunately, the President does not propose to limit this caseload growth.

The ambiguous reach of the cap: The per capita spending limits in the President's plan would be based on states' 1992 per capita outlays for non-exempt items and services and for non-exempt populations. Since there is no definition of "acute" care in the Medicaid statute, it is unclear what the full scope of the cap will be. For example, disproportionate share payments to hospitals would be exempt under the President's plan, presumably in recognition of the aggregate DSH limits enacted in 1991. But would hospital expenditures for women and children that are part of the base payment be exempt? Are day hospital treatment services for children with moderate disabilities but who do not need long term institutional care "acute"? We presume that all non-institutional expenditures for women and children and other non-elderly persons would be subject to the per capita limits, but it is impossible to know whether certain types of institutional expenditures would be swept in, as well.

The dangerous growth limits imposed on an already inadequate funding base: Beyond its disturbing ambiguity of scope, the cap proposal is dangerous, because it uses as its base for future growth limits states' 1992 Medicaid outlays. This means that states' already inadequate provider payment levels will be locked

in for all time (we assume the President envisions the cap as a permanent change in Medicaid law). The Physician Payment Review Commission already has provided Congress with extensive documentation of how extremely depressed Medicaid reimbursement levels are. A per capita cap adjusted only for the rate of inflation means that states will never be able to make upward adjustments to correct for these depressed prices unless they do so completely out of their own funds.

A per-capita cap adjusted only for inflation also means that Congressional reforms in 1989 and 1990 aimed at improving payment to community and migrant health centers and providers of maternity and pediatric care will become virtually unenforceable.[1] These changes were enacted in order to encourage Medicaid participation by more maternal and child health providers and to improve and strengthen health centers -- the one reliable system of comprehensive primary health care for America's millions of uninsured and publicly insured medically underserved persons. A cap that does not permit the real growth necessary to implement these changes (which are still in the implementation stage in many states despite the fact that their effective dates have long since passed) will spell the end of these reforms.

The impact of the cap on service growth needs: Moreover, while the cap methodology proposed by the President allows for caseload growth, it provides no room for other kinds of real growth. Like all health programs, Medicaid spending grows for a number of reasons. Table 3 shows that only 30 percent of health expenditure growth is attributable to increases in the volume and intensity of services. The proposed cap has no volume/intensity growth whatsoever. A state could never add new services or increase the scope of covered services for women and children and other non-elderly persons, no matter how important, necessary or valuable. Medical care advances, already elusive in the case of the poor, would stand still for low income women and children under the President's proposal.

Particularly vulnerable under the proposal are the major reforms in the Early and Periodic Screening Diagnosis and Treatment program (EPSDT) which you, Mr. Chairman, sponsored only three years ago. Many states are in the process of adding new Medicaid benefits for children as a result of these EPSDT expansions. The cap would all improvements in the program, since it makes no room for service growth and effectively necessitate the repeal of these improvements. No other set of reforms to date has done more for disabled children than these EPSDT changes.

Managed Care: The President claims that these per-capita expenditure ceilings, as fundamentally depressed and as structurally flawed as they are, nonetheless can be maintained in a responsible fashion, without harming beneficiaries or placing state Medicaid programs at complete financial risk for annual spending increases that exceed the limits. He claims that this can be accomplished through greater use of managed care. Indeed, the caps have been proposed in part as a means of pushing states more rapidly toward managed care.

We do not understand why anyone would suppose that responsible managed care providers and HMOs who have rejected Medicaid participation because of depressed reimbursement levels and inadequate coverage suddenly will enroll as managed care providers with added patient care responsibilities and (at least for some plans) with added financial risk assumed. This is particularly

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[1] Indeed, the cap would have such far reaching effects on current program obligations for women and children that we assume that if the President sends actual legislation to Congress it will also contain provisions eliminating many of the statute's most important eligibility, benefit, reimbursement, and administrative safeguards.

true given the fact that the proposed per capita spending limits will preclude states from making real fee adjustments in order to attract more providers. Indeed, based on past experiences with the fast-track prepaid health plan initiatives of the mid-1970s, the providers most likely to come forth in big numbers will be plans with an eye on large, prospective capitated payments and with little experience with, or attention paid to, comprehensive health service provision and risked based management for poor women and children.

Study after study has shown that managed care, while potentially of great benefit, saves no money (except perhaps some one-time savings in the case of health programs that are financed overly generously to begin with, which is certainly not the case with Medicaid). Indeed, by improving access to health care, managed care can result in short-term spending increases, as volume and intensity initially rise. Of course, this could not happen under the President's plan, since expenditure levels would be artificially frozen. Thus, the true means by which managed care is meant to save money in a Medicaid context is through reduction in services. This means that concurrent with a cap, a managed care initiative would have to give states flexibility to reduce services and payment for women and children.

The President's plan assumes that there is room to cut services. Yet as a group, women and children now comprise only about one-quarter of all Medicaid expenditures, even though they constitute over two-thirds of program beneficiaries. There is absolutely no evidence to suggest that poor women and children receive too many Medicaid services. Indeed, all evidence points in exactly the opposite direction. The recent measles epidemic, which reached its zenith in 1990, struck more than 27,000 persons, and killed dozens of children, occurred most heavily among low income, inner city infants and toddlers. These children are notoriously under-immunized and are disproportionately dependent on Medicaid. Pregnant women enrolled in Medicaid are already at risk for delayed prenatal care.

Assuming that good managed care does help poor patients find more care earlier, costs would initially rise, not fall. There will be little hospital savings to recapture from improved primary care, however. This is due in part to the fact that Medicaid hospital payments are too low to yield much in the way of savings and in part because women and children are churned off the program so quickly (the average length of Medicaid enrollment is less than a year), that short term spending increases will rarely be offset by future savings.

There is nothing wrong, and indeed, everything right, with managed care. Managed care programs that assure a medical care home for all children, prenatal care for all pregnant women, and essential health care for all Medicaid beneficiaries would be a real blessing, given the terrible barriers to sources of even basic health services that confront many of those who depend on Medicaid. But good managed care means an initial investment to assure that high quality providers are attracted to the initiative.

It is also essential to build in protections so that providers such as community health centers, public clinics and public hospitals are protected against insolvency. No health provider which is obligated by law to serve all patients in accordance with ability to pay, which is obligated by law to accept Medicaid patients, and whose patients are so poor and underserved that every penny available must be stretched to the limit to meet basic needs, should be placed at financial risk under managed care. Health centers have shown themselves to be excellent sources of managed care services. Along with public health agencies offering maternal and child health services and public and disproportionate share specialty hospitals, such as children 's hospitals, health centers should be a required element of every state's managed care plan.

But health centers and other public entities with a mission to serve the poor cannot be placed at financial risk. Risk based managed care could threaten the existence of health centers nationwide by exposing them to tremendous losses that they have no funds to absorb. And while capital reserves against loss might be a partial answer for certain providers, they are no answer for health centers, since by law, they are prohibited from building reserves.

In sum, the President's Medicaid proposal represents a thinly veiled attempt to cut spending on the least costly services for the least costly and most vulnerable program beneficiaries. This is not to say that the proposal would be acceptable were it broadened to cover all beneficiaries. It is simply unthinkable to make the health care program for the poor pay for health care expansions for other poor people. This is health expenditure redistribution at its worst.

Tax Credits

With respect to the proposed health tax credits for the poor, such credits may be of limited utility for the small number of poor workers employed at firms offering some, but unaffordable individual and family health coverage. Table 1 shows that employer insurance does not even begin to be available at significant levels to families with children until family income reaches the 150-200 percent of poverty mark -- the point at which the President's credit ends. In other words, assuming the utility of credits at all, they are targeted at the wrong population.

Most poor families, including poor working families, have no access to employer coverage at all. Their vouchers would barely cover the cost of group health coverage in many states and would not even come close to covering the cost of individually purchased health benefits. The notion of using vouchers to buy low income persons into Medicaid is simply a new twist on the President's campaign promise to extend Medicaid to the poor. We welcomed such a proposal as a step forward and continue to do so now. But it would be much more efficient to expand Medicaid in a straight forward fashion, as Senator Chafee has proposed to do, rather than through some tortured tax credit system. At a minimum, benefits should be extended immediately to all poor children under 18, as Senator Bentsen and other members of this Committee have long proposed.

Table 1. Health Insurance Coverage Status of All Children Younger than 18, by Race/Ethnicity, 1990

	Total	Covered by Public or Private Insurance	Covered by Any Private Insurance	Covered by Employer-Based Insurance	Covered by Medicaid	Uninsured All Year
All Races						
Number	65,049	56,634	46,369	39,964	11,993	8,414
Percentage		87.1%	71.3%	61.4%	18.4%	12.9%
White						
Number	51,929	45,444	39,484	34,356	7,132	6,486
Percentage		87.5%	76.0%	66.2%	13.7%	12.5%
Black						
Number	10,162	8,695	4,954	4,048	4,201	1,467
Percentage		85.6%	48.8%	39.8%	41.3%	14.4%
Latino						
Number	7,457	5,344	3,356	2,893	2,237	2,113
Percentage		71.7%	45.0%	38.8%	30.0%	28.3%

Note: Persons of Latino origin may be of any race.

SOURCE: March 1991 Current Population Survey, Bureau of the Census. Calculations by the Children's Defense Fund.

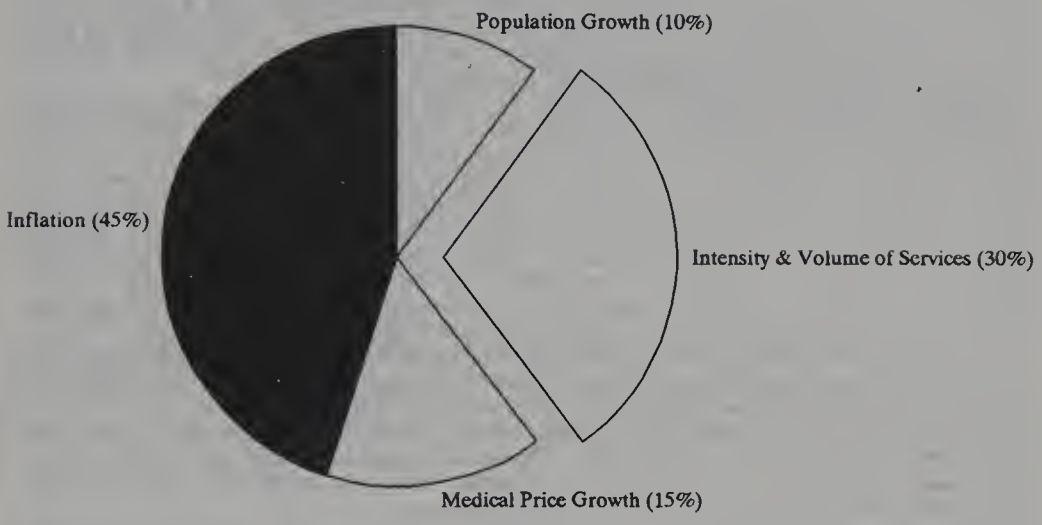
Table 2. Employment-Related Insurance, by Race/Ethnicity and Income, 1977 and 1987

	1977	1987
All Children		
Total	72.8	62.9
White	78.2	71.3
Black	52.5	38.1
Latino	50.7	39.4
Poor Children (b)		
Total	27.5	23.0
White	40.0	31.5
Black	11.0	15.9
Latino	12.5 (a)	16.1
Low Income Children (c)		
Total	63.4	47.0
White	69.0	52.1
Black	50.5	34.2
Latino	49.6	38.3
Middle Income Children (d)		
Total	83.6	79.0
White	84.2	81.3
Black	83.7	69.5
Latino	71.7	64.5
Upper Income Children (e)		
Total	85.4	86.9
White	86.9	87.3
Black	76.8	83.4
Latino	69.0	77.5

SOURCE: HIES and NMES. Calculations by the Children's Defense Fund.

a. Standard error is greater than 30 percent of the estimate.
b. Incomes below federal poverty level.
c. Incomes between 100 to 199 percent of the poverty level.
d. Incomes between 200 to 399 percent of the poverty level.
e. Incomes at 400 percent and above of the poverty level.

Table 3. Factors Contributing to the 1989-90 Increase in Health Spending



SOURCE: CRS analysis of National Health Expenditure Data.

PREPARED STATEMENT OF LARRY MATHIS

Mr. Chairman, I am Larry Mathis, president and chief executive officer of The Methodist Hospital System in Houston, Texas and chairman-elect of the American Hospital Association (AHA). On behalf of AHA's nearly 5,400 member hospitals, I am pleased to testify on the President's Fiscal Year (FY) 1993 budget proposal and on key suggested financing features of the President's reform proposal.

We understand that this Committee faces serious budget constraints, forcing difficult tradeoffs among competing needs. But if we resort to purely budget-driven decisions to inappropriately limit payments or set spending caps, we will only be fueling the crisis in our health system, not taking steps toward solutions.

The time is past when we can treat symptoms and ignore underlying causes. It's time to rewrite the policies of the past, overhaul the health delivery structure, and encourage different behaviors by consumers, providers, and payers. Only in that way will we achieve universal access to needed services at a cost this country can afford. I think it is becoming clearer to all of us that dramatic change must and will occur.

But that takes time. Meanwhile, existing health care financing programs—specifically, Medicare and Medicaid—must be adequately supported so that services currently provided to the elderly and the poor and disabled are not eroded. While we are eager and ready to work with this Committee and the Congress on the future task of reshaping health delivery, we must come to grips with the task immediately before us—ensuring that existing Federal programs meet the needs of patients and don't push providers any closer to financial collapse.

But, Mr. Chairman, I come to you today to tell you that from the point of view of those on the front lines of health care delivery, the underfunding of Medicare and Medicaid is more than a major headache—it's a migraine. The President's budget proposals would continue to underfund Medicare, which on average accounts for almost 40 percent of hospital revenue. Medicaid is even stingier, covering on average only 78 cents on the dollar for care delivered.

THE PRESIDENT'S BUDGET PROPOSAL

Hospitals can find little cause for optimism in President Bush's FY 1993 budget proposal. We do welcome his plans for modest expansions of some Federal programs to increase access to health services for selected populations. His attention to increasing resources for prevention of death and disease is necessary and important.

But these positive initiatives alone don't go far enough. We see virtually no short-term hope that there will be budgetary elbow room to deal with some of the serious shortcomings in the current payment system. As in past budget proposals, the payment increases promised are slated to be cut back—this time by $10.8 billion over 5 years. This would be achieved through a variety of means including a three-month delay in implementation of the FY 1993 update factor to PPS rates; caps on payment for laboratory services; cuts in durable medical equipment payments; and establishment of a single fee for supervisory anesthesia services.

In addition, there's another $1.9 billion in "savings" included in supplementary budget documents but not counted toward the $10.8 billion total. The money would be "saved" by extending a 10 percent reduction in Medicare capital payments after budget neutrality for capital expires in FY 1995. This is not savings, it's bad faith. Just last year, hospitals, Congress, and the Administration worked together to come up with a feasible prospective payment system for capital. Now, less than 5 months after that system took effect, the Administration indicates intentions to break that agreement and impose additional constraints on Medicare payments below Medicare's share of hospital capital investments in patient care. We believe Congress, not the Administration, should decide the level of capital spending for hospitals.

As you know, hospitals have borne their share of budget cuts to reduce growth in government spending. As part of the Omnibus Reconciliation Act of 1990 (OBRA–90), $44.1 billion was squeezed from Medicare over the 5-year period from FY 1991 through FY 1995. The President now proposes to break that budget agreement and try to carve even more out of Medicare. Besides undermining the prospective payment system, continued cuts threaten hospitals' ability to meet the needs of both Medicare beneficiaries and the rest of the population.

The President's Comprehensive Health Reform Program also suggests reductions in Medicare and Medicaid spending are possible with no harm to hospitals. That is an illusion.

Teaching hospitals in particular have been targeted by the Administration. Although the amounts are unspecified, the Administration has suggested that Medicare indirect and direct graduate medical education payments might be ratcheted down or modified to help fund the President's reform proposal. Like most hospitals, teaching hospitals lose money under Medicare.

We estimate that in 1992 teaching hospitals, as a group, will have PPS operating margins of negative 9 to negative 10 percent. Preliminary estimates for FY 1993 show these margins will continue to decline.

Teaching hospitals deserve the full support of Congress. Current Medicare payment policies recognize their special mission—training future clinicians and other technical personnel; providing access to care for those with little or no insurance; and developing, testing, and disseminating new medical technologies. Without such hospitals, the quality of medical care for everyone in this country would be jeopardized.

Another method suggested by the President to fund his reform proposal would be to cap the federal share of Medicaid by shifting to a per capita payment structure and limiting annual increases to 2 to 4 percent above the Consumer Price Index for urban areas. In fact, the Medicaid program is already severely underfunded. Nine of 10 hospitals lose money treating Medicaid patients, and the extent of losses is severe. Medicaid shortfalls have been the fastest growing component of overall hospital losses on service delivery, and in many states covered benefits are being limited rather than expanded. Ironically, curtailing payments under Medicaid would hurt the poor and medically indigent, the people that the President's proposal is intended to help.

HOSPITAL FINANCIAL STATUS

It is difficult to pinpoint with precision the impact of the President's budget on hospitals. It is possible, however, to look at the results of similar past policies as a clue to what his plans for FY 1993 might bring.

Preliminary estimates from the Prospective Payment Assessment Commission (ProPAC) show that approximately 6 of 10 hospitals lost money treating Medicare patients in the seventh year of PPS (FY 1990) and that the overall PPS margin for hospitals was –3.4 percent. AHA projections show that, since that time, the situation is worse for many hospitals. Preliminary projections for FY 1993 indicate the

aggregate average PPS patient margin will be between –12 to –15 percent. By then, 7 of 10 hospitals will lose money treating Medicare patients. And averages are just that, averages, masking even deeper losses incurred by many hospitals when they care for Medicare beneficiaries. We project that in FY 1993 approximately 900 hospitals will either barely break even or lose up to 10 percent in treating Medicare beneficiaries. Another 900 will lose between 10 and 20 percent, and 2,000 hospitals—that is over one-third of our nation's community hospitals—will lose more than 20 percent providing Medicare inpatient services.

Clearly, Medicare has been cut to the bone. In 1990, AHA estimates that PPS hospitals experienced approximately a $3 billion shortfall in care provided to Medicare inpatients. Add this amount to the $9.5 billion in unsponsored care and $4.6 billion in Medicaid shortfalls in 1990, and you have close to $17 billion dollars that hospitals had to attempt to recover from a dwindling base of private payers that year.

The result? Hospitals' charge structures have become distorted, causing confusion among patients and the public about what care costs, what we charge, and who pays what. In short, hospitals get a black eye for trying to remain solvent. Furthermore, hospitals are less able to fund growing Medicare and Medicaid shortfalls and unsponsored care through other services. This increased financial pressure will inevitably strain hospitals' to the limit. And our options are few—cut services to our communities, lay off workers, or scrimp on patient care. We won't do the latter. And I don't think you would want us to do the others.

Under PPS, hospitals were given incentives to become more efficient. Hospitals responded. Lengths of stay went down as care shifted from the inpatient to the outpatient setting and other less expensive alternatives. And we trimmed inpatient capacity. Yet costs still go up. It must be understood that much of the rise in hospital costs is beyond hospitals' control. Prices hospitals pay for resources to care for patients are rising at a significantly higher rate than prices in the general economy. The Consumer Price Index climbed about 41 percent from June 1982 through June 1991 while the hospital market basket increased 72 percent. More than half of community hospital expenses are for wages, salaries, and employee benefits, which are growing faster than the rate of inflation, spurred on by staff shortages in nursing and other patient care professions. Another third of hospital expense is for items essential to patient care, including medical supplies, pharmaceuticals, utilities, food, and housekeeping supplies.

What's more, the underfunding of Medicare PPS also has served to spotlight its flaws. Not surprisingly under these circumstances, well-intentioned efforts to improve PPS equity adjustments have met with serious problems. There is still no adequate adjustment for variations in costs tied' to differences in patients' severity of illness. Hospitals are paid the same under Medicare even when a patient requires more intensive use of resources. Studies show that hospitals with a heavier burden of very sick and, therefore, very costly patients (outlier cases) generally have negative margins. Outlier payments under PPS only slightly mitigate the financial impact on such hospitals.

Another unsolved problem: PPS' area wage index. Because the hospital area wage index is based on political boundaries and not on hospital labor markets, this adjustment has been a problem since the beginning of PPS. By establishing the Medicare Geographic Classification Review Board (MGCRB), Congress tried to solve this problem by giving hospitals the opportunity to be reclassified into another nearby geographic area that had a higher standardized payment rate or a higher wage index. Nearly 1,000 hospitals were reclassified in FY 1992, in most cases for their wage index. Funding of these reclassifications was obtained through a substantial reduction in the payment increase promised to urban hospitals.

The large number of Medicare geographic reclassifications, as well as the size of the budget-neutrality adjustment, made both the flaws in the payment methods and the inadequacy of PPS funding abundantly clear. These events revealed a system gone awry.

The major lesson learned from Medicare geographic reclassification: you just can't fix PPS equity problems when overall payment is inadequate. Without additional funding, new or changed PPS equity adjustments will help some hospitals but seriously damage other, equally vulnerable institutions. Without new funding to implement Medicare geographic reclassifications and other PPS equity adjustment changes, budget-neutrality adjustments will further damage the financial condition of many vulnerable hospitals.

AHA is working to identify the kinds of PPS adjustments that could resolve inequities such as those uncovered by geographic reclassification. We will continue that work with ProPAC and Congress this year so that together we can fashion a better payment system.

Problems with Medicare payment systems are not limited to payment for inpatient services under PPS. How we are reimbursed for outpatient services under Medicare is confusing and fragmented. A single outpatient visit can result in payments under as many as four distinct payment systems. This is the result of piecemeal changes designed to limit costs. But the biggest by-product has been enormous confusion.

The Health Care Financing Administration (HCFA) now wants to compound this confusion by imposing a bundling regulation for hospital outpatient services. This is no bundle of joy—it's a mule that would make hospitals financially liable for services they do not provide and costs they cannot control. The rule could also put hospitals at risk under fraud and abuse and antitrust laws. What's needed is what has already been requested by Congress—the long overdue plan from the Administration for comprehensive reform of the Medicare outpatient payment system. AHA supports such reform and in the meantime urges delay of the bundling regulation as well as any other piecemeal Medicare outpatient payment changes until Congress approves a new, rational system.

FEDERAL GOVERNMENT RATE SETTING

In closing, Mr. Chairman, because we are here today discussing Medicare payment and funding levels, I think it's important to share with you our concern about proposals to impose a Federal government-style payment system on all purchasers of health care.

If indeed Medicare is the role model some would emulate, all patients and all hospitals would suffer. It would amount to letting the Federal government underpay for everyone, not just the poor, elderly, and disabled. Not only would the availability and quality of health care services be jeopardized, incentives for efficiency, innovation, and development of new medical technologies would disappear. Americans would be left with a Federal system based on the current fragmented Medicare system with all its conflicting incentives. Rather than more coordinated and better managed care, lit would lock in today's failed system. Top-down regulatory limits do not address the root causes of health care cost increases.

Government rate setting requires trust and confidence in the Federal government to keep its promises to adequately fund whatever program it creates. The Federal government has not kept its promise to adequately fund Medicare. As long as health care financing is subject to annual budget battles, there's little reason to believe government will try to keep its end of the bargain on an even larger scale.

This concern is not unfounded. I point to the President's proposed "entitlement cap" as evidence that budget-driven health policy is still with us. Were this cap to become law, health care decisionmaking based solely on budget policy would be institutionalized. Arbitrary spending caps like this will undermine the success of any proposed reforms of our system, and they should be rejected.

Mr. Chairman, I understand the difficulties you and the Congress face in achieving fairness within budget constraints. AHA wants to be part of a far-reaching solution that not only looks to widen access and contain costs, but holds out the promise of better care for patients in the bargain. We look forward to working with this Committee as you shape the FY 1993 Medicare and Medicaid budgets.

PREPARED STATEMENT OF SENATOR DON NICKLES

Mr. Chairman, we face an enormous task . . . how do we get a $5.7 trillion economy moving with an economic package totalling less than $100 billion in incentives, which represents less than 2% of our Gross Domestic Product.

During the month of December, both the Finance Committee and the Ways and Means Committee held hearings on reviving the economy. The consistent theme among those testifying was that Congress was very limited in how it could respond to the current economic downturn. In the days of old, the federal government could rush in with a mix of fiscal stimulus and perhaps jump-start a weak economy. With a projected deficit of $400 billion for this fiscal year, those options are now severely curtailed.

Mr. Chairman, the bottom line is that the federal government is broke and is racking up debt faster than projected. I imagine if Uncle Sam was a homeowner applying for a loan, he'd surely be turned down. No one will lend to a person who has negative cash flow and cannot reduce their current debt load.

Last week, the House Ways and Means Committee reported a package which was supposed to stimulate the economy. In the final analysis, believe it will be discredited as providing little, if any, economic stimulus. In my estimation, the package simply reshuffles the deck.

The proposal resorts to business as usual by appealing to those from whom you can garner the most votes. For example, to secure the support from those members affected by the so-called luxury tax, the plan repeals this 1990 provision based upon that fact that thousands of jobs were lost in that industry. This ill-conceived tax was aimed at the "fairness" argument which purports to even the playing field by soaking the rich. Unfortunately, those who were soaked when the boating industry sank were the workers it employed.

Believe it or not, the Ways and Means package, while repealing the luxury tax because of its negative impact on workers, turned right around and hiked the top bracket and placed a surcharge on the wealthiest taxpayers. While this may have some short-term appeal, I believe the working men and women of America will once again bear the brunt of the burden.

In contrast to the Ways and Means plan are other proposals which will stimulate the economy and promote economic growth. First, is the proposed reduction in capital gains taxation. The proposal in the House Ways and Means Committee is inadequate and provides little economic incentive. The President's proolosal is far superior to that of the House plan and creates sufficient incentive for investment in capital assets which, in turn, create jobs and stimulates the economy.

We should also enact an investment incentive for the purchase of equipment. Under the President's plan is a short term investment tax allowance which will allow businesses to write off an additional 15% of the purchase price of equipment acquired this year. This will give the economy a short-term boost in order to help create jobs and make our industries more competitive. Other proposals call for an investment tax credit for new equipment. I would favor an investment credit with a higher credit in the earlier years, reducing in the later years, thereby creating greater incentive to invest now.

There are other proposals calling for changes in the passive loss rules which I believe will help our struggling real estate industry. By modifying the passive loss rules, real estate investors would be allowed to deduct out-of-pocket expenses against other income as other businesses do. The 1986 changes caused a decline in real estate values and thus has increased the cost of resolving the troubled banking and thrift industry.

We need also to consider changes in the Alternative Minimum Tax to allow industry to exempt certain equipment purchased from the "adjusted current earnings" portion of the Alternative Minimum Tax. We need to adjust the alternative minimum tax and allow business people to deduct their accelerated depreciation and take that as a deduction, as an expense. Changes in the Alternative Minimum Tax will mean real long-term incentives. Basically, we have a tax surcharge on otherwise legitimate tax deductions.

This onerous tax has particularly hit hard in the oil and gas industry. Today's bad news is that rig count statistics are the worst ever. Baker Hughes reports that the rig count stands at 653 for the week ending January 31. This is the lowest level of drilling activity since records were begun in the 1940's.

But the rig count is not just a statistic. It is an important economic indicator that relates to our prospects for economic growth since energy is an indispensable input. It is the barometer that measures our future ability to produce domestic energy.

A rig count of 653 indicates that the industry has entered a period of accelerated decline. The nation's domestic oil production is falling at annual rate of 300,000 barrels a day, and foreign imports are rapidly approaching fifty percent of our domestic needs. We have lost 326,000 jobs, almost half of the oil field worker jobs since the peak in 1982 when the rig count was 3,105.

Independent producers have been devastated by a combination of low oil and gas prices and high taxes. Every rig that shuts down means jobs that are lost and increased dependency upon foreign oil for our energy needs. I strongly believe that tax relief is needed to save the domestic industry from collapse.

The time to act is now. The independent producers say that unless tax relief is provided, the industry will collapse. With the energy bill on the floor of the Senate and the President's budget before Congress, it is time to act and act decisively.

I am convinced that the Alternative Minimum Tax relief is the single most important agenda item for the oil and gas industry. It does little good to talk about extending incentives unless we remove Alternative Minimum Tax impediments.

When a recession coincides with sustained low oil and gas prices, the Alternative Minimum Tax works like a severe penalty that gets progressively worse the longer the taxpayer falls under it. The longer prices are low and profits thin, the harsher is the Alternative Minimum Tax's impact.

I have called for the removal of intangible drilling costs and percentage depletion as preference items under the Alternative Minimum Tax. Under current law, when percentage depletion and intangible drilling costs are added back to income in cal-

culating Alternative Minimum Tax tax liability, it can result in a 70 to 80 percent effective tax rate for some producers. The result is indisputedly punitive, if not confiscatory.

In crafting an overall economic package we must protect against Congress doing more harm than good. The AFL–CIO at their winter meeting in sunny Bal Harbour, Florida on Monday, called on Congress to add $60 billion to the deficit for what it termed was a "fiscal stimulus." I will agree with them that this will certainly be a "stimulus" to the economy . . . much like the rotten sushi recently consumed by our Olympic hopeful. Any movement to increase the federal deficit will certainly send chills throughout the markets and possibly precipitate an economic Armageddon.

The private sector will be the engine that pulls this economy out of its doldrums. If we continue to pile up debt, we will surely short-circuit any benefits the economy can generate. It would be better for Congress to do nothing than to create deficit-financed stimulus, either by reducing taxes or increasing spending. The greatest obstacle to productivity and growth in our economy right now is the federal budget deficit.

I've said many times that our federal government it overspent and not undertaxed. It is a lack of spending control, not a lack of funding, which has caused the United States to become a major debtor. Congress spent $70 billion more in 1991 than in 1990, an increase of 6 percent. This followed on 1990's record spending growth of $107 billion, or 9 percent.

The 1990 Budget Agreement, which I opposed, was a tribute to the tax-and-spend philosophy. Just as the physicians of old believed you could cure a sick patient by bleeding them with leeches, Congress last year approved a budget which tried to cure a slowing economy by bleeding the taxpayer.

In 1970, federal taxes consumed 19% of our Gross National Product, which was during the Vietnam War and after the greatly expanded social programs of the sixties. In 1980, this ratio remained at 19% and still held true in 1991. This shows that the federal government is taking in its fair share of taxes and we must hold the line.

Now is the time for aggressive ideas to attack our bloated federal bureaucracy . . . some of the ideas have been around this town a long time, others are new. The American people are looking for leadership. There are some important steps we can take:

- First, a one-year spending freeze would save billions of dollars next year, and hundreds of billions over the next five years;
- A balanced budget amendment to the U.S. Constitution would help restore the confidence of the people and the markets;
- A line-item veto would give the President a way to fight unnecessary spending:

Accomplishing these goals would allow Congress to immediate steps to improve our economic health, including the enactment of investment incentives, assistance for real estate markets, IRA enhancements, tax incentives for the energy industry, and other economic recovery policies.

Over the last year, a war and the collapse of communism have taught us that our nation's ideals are right and just, and because of this we have enjoyed a dramatic resurgence of patriotism and pride in our country. Yet all these things are now faltering on a weak economy and a lack of confidence in Washington.

Prepared Statement of Corrine Parver

Mr. Chairman and Members of the Committee: I am pleased to have this opportunity to testily before you today. My name is Corrine Parver. I am President and Chief Executive Officer of the National Association of Medical Equipment Suppliers (NAMES), a non-profit association representing over 2100 home medical equipment (HME) suppliers operating in over 4500 facilities nationwide. Based upon individual patient needs and according to physicians' prescriptions, NAMES members lavish a wide variety of equipment, supplies and services to Medicare beneficiaries for home use. These items range from traditional medical equipment such as hospital beds and walkers to highly sophisticated services such as oxygen ventilators; parenteral and enteral supplies, which provide nutrition via equipment to individuals who cannot eat normally; apnea monitors, which allow parents to closely guard high-risk infants' breathing; and technologically-advanced equipment such as power wheelchairs, which are custom-designed for the needs of persons with disabilities.

My testimony will focus on the adverse impact that further HME payment reforms, as proposed in the Administration's Fiscal Year 1993 Medicare budget, would

have on the ability of the HME services industry to continue providing high quality products and services to the elderly and people with disabilities.

Medicare expenditures for the HME benefit in 1991 were estimated at $1.6 billion and are projected to total $1.8 billion in 1992.[1] Previous Congressional Budget Office (CBO) estimates that predicted Medicare HME outlays would rise to $1.8 billion in FY 1990 and $2.1 billion in FY 1991 have proved faulty. As well, the revised "baseline" overlay estimates for HME dropped 17 percent for FY 1990 and 24 percent for FY 1991. These figures become significant in light of recent payment cuts achieved through annual budget reconciliation acts, id the fact that HME outlays represent approximately only 2 percent of the total Medicare program expenditures.

The HME suppliers represented by NAMES provide high-quality, 24 hours a day, seven days a week, cost-effective home care services which allow people to recuperate from an illness or injury in their own homes surrounded by family and friends. HME allows individuals to enjoy independence with dignity and thus a better quality of life. Throughout our discussions today, let us not lose sight of the fact that HME as a part of home care offers a practical and cost-effective alternative to the continuing high costs of institutionalized care. As the spiraling costs of health care continue to fuel the national debate about how best to control expenditures while also providing quality care to Americans in need of these services, it makes sound economic sense to recognize HME as an efficient and undeniably compassionate mechanism for providing needed health care in the home. Yes, the HME industry is growing. But the growth is due to expanding patient needs and the ever-increasing demand for more medical care to be provided whenever possible in other than an institutional setting—and not because of increased Medicare reimbursement.

As with any relatively young industry, I candidly acknowledge there have been problems with some individual HME suppliers taking advantage of existing loopholes in the Medicare program. Reports of certain abusive business practices by some unscrupulous people who have orchestrated so-called "scam" telemarketing operations or engaged in other such practices under the guise of operating an HME company are known. But at best, NAMES believes these unethical suppliers represent less than ½ of 1 percent of the HME services industry. Nonetheless, NAMES has taken the lead in encouraging Congress to enact tough legislation to eliminate even those few individuals who not only damage an otherwise quality industry, but also cause unnecessary federal expenditures and in so doing exploit the elderly. In fact, such legislation has been introduced in both the House and Senate. Two bills, S. 1988 and S. 1736, currently pending before this Committee, would strengthen the standards under which HME suppliers operate and also provide for other needed areas of reform.

Ethical HME suppliers do much more than just deliver home medical equipment to Medicare beneficiaries and others—they set up the equipment, train patients and their caregivers on how to use the equipment properly, service the equipment 24 hours a day, every day and complete expensive, ever-increasing Medicare paperwork for their patients. This high level of home care service must be encouraged—not destroyed.

Despite the critical role which home care plays in the entire health care spectrum, and the fact that needed industry reforms currently are being considered by Congress, HME continues to be singled out by the Administration for budgetary reductions to such a severe level that I am concerned the ultimate effect may well be the dismantling of the entire HME services industry. HME is a small segment of the health care industry, accounting for only approximately 2 percent of the overall Medicare budget. Yet over 14 percent of Medicare Part B payment cuts in the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990)—some $215 million—came from HME. This $215 million in cuts, which was in addition to the $80 million in HME payment reductions in OBRA 1989, represents over 3 times the industry's proportional share of reductions. Significantly, over a five year period, the effects of the OBRA 1990 payment cuts alone will be to reduce outlays for HME by $2.2 billion.

Now, again, in its FY 1993 budget, the Administration proposes yet another series of drastic cuts that directly affect the HME industry, despite these professed views of the National Republican Platform:

> "We will encourage the trend in the private sector to expand opportunities for home health care to protect the integrity of the family and to provide a less expensive alternative to hospital stays. We want to ensure flexibility for both Medicare and Medicaid in the provision of services to those who need them at home or elsewhere."

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[1] House Ways and Means Committee "Green Book."

The proposed HME cuts, totaling almost $500 million by 1997, further would aggravate the industry's ability to meet the growing needs of Medicare beneficiaries served by HME suppliers. The Administration notes that additional across-the-board reductions in HME reimbursement are 'justified by numerous reports of fraud and abuse" in the HME industry. This is frank demagoguery—an appeal to the emotions unsupported by logic.

Material used to support the President's initiative include a 1991 GAO study on "Medicare: Effect of Durable Medical Equipment Fee Schedules on Six Suppliers' Profit Margins," porting to indicate that HME suppliers reap excessive profits from the Medicare program. But a careful examination of the GAO Report by an independent consultant, which I submit for the record of this hearing, clearly reveals that flawed sampling and accounting techniques applied to an extremely small data sample (only six suppliers were surveyed) render the results valueless. The GAO findings are at extreme variance with other industry surveys, and indeed, with other well-accepted techniques for calculating statistical reliability. The probability that GAO accurately states HME profitability ratios is less than ½ of 1 percent.

Furthermore, *any* report evidencing high business profit margins in Medicare along with extremely large losses in non-Medicare is suspect from a common sense standpoint. It is well-established that, for years, Medicare and Medicaid have paid less than their fair share for HME services, thus shifting costs to the private insurance industry. Despite the crucial fact that GAO actually admits it was impossible to offer projectable results due to the small data sample, the Administration nonetheless relies heavily on GAO's insupportable findings to develop its FY 1993 Medicare budget for HME. Again, the logic inherent in the Administration's reliance on this GAO Report, which is methodologically wrong, is at best useless and at worst downright misleading as a guidepost to proper policy—it simply makes no sense.

Particularly disturbing in the Administration's FY 1993 budget, as reflected currently in H.R. 4150, the "Economic Growth Act of 1992," is the extremely broad discretionary authority granted to the Secretary of Health and Human Services (and thereby, HCFA) to make payment determinations for HME items, ostensibly to reflect "current market factors." If this legislative provision is enacted, Congress, in essence, will have abrogated its proper legislative authority to regulate HME reimbursement levels, allowing HCFA virtually unlimited power to effect whatever HME payment reforms it deems proper, with no further guidance from our consultation with Congress. On behalf of HME suppliers throughout the country, I respectfully request the Committee outrightly to reject this proposal in its entirety.

Mr. Chairman, it was only last year that the HME services industry sought Congress' help in forestalling HCFA's implementation of HCFA's faulty HME fee schedules that were riddled with errors and inconsistencies, until such time as appropriate data corrections could be made. Such actions help demonstrate the necessity for constant Congressional oversight of Administration activities. The blanket delegation of authority sought by the Administration is unwise economic and social policy and downright frightening.

The legislative provisions addressing national health reform in the President's package would empower HCFA to consider *any* combination of Administration proposals that Congress already refused to enact in prior years—without the benefit of debate and discussion in a Congressional forum. Despite the thinness of its rationale, the Administration boldly advances a series of proposals that would amount to conferring on HHS and HCFA *carte Blanche* authority to set Medicare reimbursement for HME at-will in the future with no further guidance from or consultation with Congress. For example, the Administration seeks unfettered discretion to determine the amount of annual reimbursement CPI updates, and even whether there will be any update at all. This provision alone amounts to authority to starve an integral part of America's home care system out of existence in a very short span of time.

If enacted by Congress, the Administration could change payment policy for HME in the following manner, as previously articulated by HHS and HCFA:

- Establish competitive bidding for oxygen and oxygen products;
- Reduce oxygen reimbursement by 5%;
- Set a national cap on reimbursement for HME, including orthotics and prosthetics, at the national median;
- Establish fee schedules for parenteral and enteral nutrition and supplies; and
- Recategorrze nebulizers and aspirators from "frequent servicing" to "purchase."

NAMES categorically objects to each and every proposal.

The Administration seeks authority to institute competitive bidding for oxygen, demonstrating once again that the bureaucracy fails to learn from its past, well-pub-

licized mistakes. As *The Washington Post* recently noted, the Department of Defense has proven again and again that competitive bidding, even for mundane items like fruitcake and ketchup, entails volumes of product specifications, a huge bureaucracy and a glacial pace of operations. As for cost-containment, it is a joke, a scandal, or both, depending on one's point of view. NAMES strongly opposes competitive bidding in general for the HME services industry.

With any competitive bidding system, the first issue to consider must be a determination of what level of service provided by HME suppliers the government is willing to pay. Otherwise, the government rightly should be concerned that the HME service component—so integral to assuring patient health and safety—may diminish or disappear. As noted above, competitive bidding is known to work poorly both for the Defense Department and the VA, places where it already is used on a large scale similar to what Medicare would require. Yet, HCFA, with a chronic problem of carriers under-funded to meet even their current workload, anticipates that instituting competitive bidding will be successful.

In support of its proposal, HCFA cited a competitive bidding program for oxygen used currently by the Veterans Administration (VA). Significantly, VA hospitals have experienced deficiencies documented by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) due to the poor quality of home care provided by VA contract winners. Medicare would have to expect similar, if not greater, problems in access and quality. The VA, once acquiring signed contracts in certain states, has monitored providers for provisions of services, only to find they have no awareness of home oxygen and HME items regarding quality, appropriateness of equipment, various types of equipment, safety features of equipment, and current pricing of equipment. Review of signed "low bid" contracts across the Southeast and Southwest VA system have revealed hidden charges.

Competitive bidding for certain selected HME items has been tried and subsequently abandoned in a number of states. There are enormous complexities involved in dividing the entire nation into multiple and reasonable service areas. Few suppliers provide all possible HME services and therefore it would be necessary to define different service areas for different kinds of equipment. It currently takes on average 90 days for HME suppliers to get paid; as a result, it is highly unlikely any company would have the capital necessary to expand into new services in order to take on large competitively bid contracts. As well, it is very hard to design and administer a competitive bidding process such as described above without damaging the market. If a winning bid is awarded solely to one provider, this certainly will drive many small companies out of business; the sole winner in future years thus would have a considerably reduced level of competition. If multiple winning bids are approved, then no incremental benefit exists for increased volume. Furthermore, according to a recent study on competitive bidding conducted for HCFA, suppliers' costs of doing business with Medicare are higher than with the VA or Medicaid programs. Thus, HCFA could not expect to achieve the cost savings associated with the VA program unless HCFA also implemented the cost-saving administrative features associated with the VA program.

For these reasons, NAMES submits that Congress must reject the Administration's HME proposal in Section 804 of H.R. 4150. Adoption of this broadly-worded provision as it is currently drafted would allow the Secretary to put forward a competition bidding program that seriously could undermine provision of quality HME in this country.

Regarding oxygen fee reductions: HME payment reforms in OBRA 1987 were designed to effect a five percent reduction in oxygen expenditures. In many states, however, actual reductions approached 15–20 percent, in large part because the HCFA data base used to calculate reimbursement rates for oxygen supplies and equipment included patients who would not be eligible for such products under today's more stringent coverage rules. Thus, oxygen reimbursement already is dangerously low in many states. An additional proposed five percent reduction implies in real terms total oxygen reductions of well over 35 percent since OBRA 1987 was enacted. Beneficiary access to needed oxygen services already has been limited in certain markets across the country, particularly in rural states such as West Virginia and in states where the geographic terrain renders oxygen delivery and servicing difficult. Additional reductions at this time thus would be devastating for continued access to care by beneficiaries.

Regarding setting HME payments at the national median: As you know, Congress abolished payment for HME according to the old reasonable charge methodology in OBRA 1987 and substituted regional fee schedules in its stead. In OBRA 1990, Congress eliminated regional pricing in favor of a phased-in national fee schedule. By 1993, the pricing disparities between costs on the one hand and Medicare payment amounts in various states on the other will disappear, due to the completed phase-

in of national pricing. Thus, imposing an additional change at this time by setting a single national payment rate at the median for all HME items would be counterproductive.

NAMES year-long ongoing discussions with HCFA to correct HME fee schedules because of data integrity problems supports the contention that the data base used for these calculations is severely flawed. It is for this very reason that fees are calculated at the weighted *mean* rather than the *median,* so as to minimize the harmful effects of using a flawed methodology for budgetary calculations. In recognition of these problems, several Members of Congress requested a study to determine what types of geographic adjustments may be necessary for HME. Thus, it would be an unnecessary administrative burden to impose additional changes prior to the study's completion by calculating the fee schedules at the median for any item of HME, prosthetics and orthotics, or parenteral and enteral nutrition, particularly when the final phase-in to a national fee schedule will be completed by January 1993.

To address the problem of abusive business practices in the HME industry, the proper response from Congress should be to target the abusers. To mindlessly reduce HME reimbursement across the board does nothing to punish abusers or extricate them from the program. Moreover, it "punishes" the legitimate HME services industry for the sins of the few. Fortunately, Congress has credible alternatives—in the form of S. 1988 and S. 1736, as discussed previously, and on the House side, H.R. 2534. NAMES actively supports these bills and, on behalf of the majority of ethical HME suppliers, calls on this Committee for its support of this legislation as the proper policy response to reported abusers. To adopt the Administration's logic is equivalent to yakking Senators' credit cards because a few House colleagues bounced checks!

In closing, NAMES recognizes the difficulties faced by Congress and this Committee in developing a responsible and effective legislative package that will address America's health care needs as well as our needs for fiscal restraint in government spending. Notwithstanding, NAMES submits that it is counterproductive to erode an industry which allows people to be discharged sooner from an institution and permits people with severe disabilities to lead productive lives away from an institution. As our nation's elderly population increases and as advances are made in HME services, medical technology should be preserved and expanded.

The HME industry is a valuable, increasingly vital element in our nation's health care system. This industry truly helps make homecomings possible. In an era of increasing cost-consciousness and concern about the long-term care of our nation's elderly and people with disabilities, it makes plain policy sense to preserve the very benefit that provides home care services in the most cost-effective and yet compassionate fashion.

For these reasons, Congress should reject outright the Administrations' ill-conceived reimbursement proposals and, instead, should concentrate on passing H.R. 2534 and S. 1988, for which there is documented need. I will be pleased to answer any questions you may have.

Prepared Statement of Marshall Plummer

My name is Marshall Plummer, and I am the elected Vice-President of the Navajo Nation, the country's largest Indian tribe. I testify today in support of the Navajo Nation's proposals for federal tax incentives to help address the unconscionable levels of unemployment and poverty that exist in Indian country throughout this nation.

At the outset, I wish to convey to you, Mr. Chairman, and Members of the Committee, the sincere appreciation of our President, Peterson Zah, for this opportunity to appear before the Committee -- as well as his frustration that he was unable to be here to testify himself. Unavoidably, today's hearing conflicted with President Zah's long-scheduled meeting in Nevada with Secretary of the Interior Lujan and others concerning water rights issues of critical importance to the Navajo people. Please be assured, however, that the issues about which I testify today are equally important to the Navajo Nation, as economic development is one of the highest priorities of our Administration. President Zah's prepared statement is attached, and I would request that it be considered as part of the testimony that I deliver here today.

I also want to express our great appreciation to Senator DeConcini, a good friend of the Navajo and of all Indians, for his personal efforts that led to this opportunity to testify on issues of urgent import for Indian country. Finally, I want to acknowledge and thank Chairman Daniel Inouye, Co-Chairman John McCain and other Members of the Select Committee on Indian Affairs, including Senator Daschle, who also sits on this Committee. The tax incentives proposed by the Navajo Nation have their genesis in past legislative proposals from the Select Committee on Indian Affairs that have enjoyed support from both sides of the aisle.

Conditions in Indian Country

I come before this Committee to attempt -- with all the persuasive powers at my disposal -- to convey the following message: that while there are many Americans who are hurting during these economic hard times, no single segment of our society is hurting worse than the American Indian. The conditions of poverty that persist throughout Indian country are unspeakable, and the levels of unemployment are staggering.

As Chairman Inouye reported during his Committee's 1989 hearings on Indian economic development:

> **The unemployment rate on the majority of Indian reservations is simply incomprehensible** to the average American. During the height of the so-called Great Depression in the 1930's, unemployment averaged 25 to 30%. **In 1989 the average rate in Indian country** is **52%!**

Just last July, Chairman Inouye explained in hearings before House Ways and Means that "[o]ne thing links almost all of these [Indian] groups: **alarming rates of unemployment that range from an average of 56% to a high of 97%;** a lack of economic infrastructure, and all of the associated problems that plague any chronically-depressed community."

The result is that here, within the borders of the United States of America, most reservation Indians live under conditions far worse than exist in many of the Third World countries to which our Government provides substantial foreign aid. Under circumstances in which Indians lack many of the items that other Americans take for granted, meaningful action by the Congress that can attract investment and jobs to Indian country will also address basic questions of human dignity.

Navajo Nation Tax Incentives Proposal

New approaches are urgently needed to promote the type of economic development on our reservations that can better the lives of our people.

The Navajo believe -- as do many other Indian leaders who have advised us of their support -- that an appropriate new approach to this problem is through federal fiscal policy. In particular, the Navajo urge that the Congress put into place federal tax incentives that can help induce private sector investors to consider the potential for job-creating opportunities in Indian country.

The Navajo Nation has previously submitted to the Committee its proposal for two related tax incentives that complement certain national strategies now under discussion to revive the overall United States economy.

First, the Navajo Nation proposes an investment tax credit ("ITC") targeted to Indian country. This so-called "Indian reservation credit" is geared specifically to reservations where Indian unemployment levels are unconscionable -- **the credit being limited in its applicability to reservations having an unemployment rate exceeding the national average by at least 300%.**

The Indian reservation credit would offer a higher percentage credit for investment in Indian country than would otherwise be available under a nationwide ITC. This differential is absolutely essential in order to help mitigate unique problems endemic to investing in Indian country -- particularly the lack of infrastructure -- which are not commonly shared by other depressed areas. Without such a differential, an ITC (or any other tax incentive, for that matter) would essentially be useless for reservation economic development. This is so because Indian country -- both historically and at the present time -- does not compete on a level playing field with even the most economically distressed non-Indian areas, due to "double taxation" by the states, infrastructure deficiencies and related problems.

Second, the Navajo Nation proposes an Indian employment credit aimed at increasing employment of Indians on reservations. A 10% credit to the employer would apply to qualified wages and qualified health insurance costs paid to an Indian. An added incentive -- a significantly higher credit -- would be available to reservation employers having a workforce with at least 85% Indians. The credit, which focuses on job creation, would be allowed only for the first seven years of an Indian's employment.

These complementary investment and employment credits would be available directly to the private sector employer, and do not entail the establishment of a new governmental bureaucracy. Even more importantly, these programs only cost the Federal government if they work. In that event, increased Federal revenues from increased employment -- along with the anticipated decrease in public assistance payments -- should render these proposals, at worst, revenue neutral.

Conclusion

The Navajo Nation recognizes the extraordinarily difficult task facing this Committee as it weighs various proposals and attempts to fashion broad-ranging national policies that can help to revive the United States economy. On the other hand, I respectfully ask the Committee to recognize the seriousness of the unemployment problem in Indian country, and the urgency with which it must be addressed.

This year's tax bill provides Congress a unique and timely opportunity to move along a different path to promote Indian country economic development. That path -- federal tax incentives -- lies within this Committee's jurisdiction. In this, the Congressionally-designated "Year of the American Indian" (P.L. No. 102-188), I urge the Committee

to incorporate within its revenue package these modest -- but extremely important -- tax incentives, so that American Indians are not once again left behind, or left out altogether.

As President Zah has stated:

> Helping American Indians to help themselves is neither a Democratic issue nor a Republican issue; it's not a conservative policy or a liberal policy; it's not even a "special interest" issue. Rather, it is a "human" issue that must, and deserves to be, addressed from a **national perspective on a bipartisan basis,** and with a real sense of urgency warranted by the deplorable conditions existing in Indian country -- conditions which truly are a national disgrace.

I thank the Committee for its consideration of these issues that are so important to Indian country, and I strongly urge the Committee to adopt the Navajo Nation tax incentives proposal. These incentives will help level the playing field by providing tribal governments and Indian country business planners with additional tools to compete for the private sector investment and jobs that are so critical to the well-being of our people.

February 19, 1992

* * *

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Committee on Finance
United States Senate

Hearings on Economic Growth and the President's Budget Proposals

STATEMENT OF PETERSON ZAH,
PRESIDENT OF THE NAVAJO NATION,
ON FEDERAL TAX INCENTIVES TO PROMOTE
INDIAN ECONOMIC DEVELOPMENT, EMPLOYMENT, AND
SELF-DETERMINATION

My name is Peterson Zah, and I am the elected President of the Navajo Nation, the country's largest Indian tribe. The Navajo thank you, Mr. Chairman, and Members of the Committee, for this opportunity to testify at these important hearings. I also want to express our great appreciation to Senator DeConcini for his personal efforts on our behalf that led to this opportunity to present testimony on an issue of critical importance to all of Indian country. In addition, I want to acknowledge and thank Chairman Inouye, Co-Chairman McCain and the Members of the Select Committee on Indian Affairs for their traditional support and encouragement, including their tireless efforts over the years to promote Indian country economic development. The Navajo proposals which I discuss below draw heavily upon various legislative initiatives that were introduced in the past by those two distinguished Members, and that enjoyed strong bipartisan support among the Members of Senate Select.

Introduction

The Navajo reservation is the largest in the United States; along with Tribal fee and other non-trust lands, Navajo country covers almost 28,500 square miles within the states of Arizona, New Mexico and Utah. This land area is nearly the size of New England.

However, the current economic downturn in New England pales in comparison to economic conditions prevalent in the Navajo Nation and throughout Indian country. For example, **the Navajo unemployment rate ranges from 38% to 50%**, depending on the season. Even worse conditions exist elsewhere in Indian country throughout the United States. As Chairman Daniel K. Inouye reported during the Senate Select Committee's 1989 hearings on Indian economic development:

> **The unemployment rate on the majority of Indian reservations is simply incomprehensible** to the average American. During the height of the so-called Great Depression in the 1930's, unemployment averaged 25 to 30%. **In 1989 the average rate in Indian country is 52%!**

Just last July, Senator Inouye explained in hearings before the House Committee on Ways and Means Subcommittee on Select Revenue Measures that "[o]ne thing links almost all of these [Indian] groups: **alarming rates of unemployment that range from an average of 56% to a high of 97%**; a lack of economic infrastructure, and all of the associated problems that plague any chronically-depressed community."

Surely during these economic hard times in America there are many people who are hurting -- but just as surely, there is no single segment of our society that is hurting worse than the American Indian.

This Congress, just over two months ago, designated 1992 the "Year of the American Indian" (P.L. No. 102-188). This Committee has the opportunity to help make good on that commitment in a way that can begin to address the "incomprehensible" unemployment levels throughout Indian country.

Disincentives to Investment in Indian Country

One of the highest priorities of my Administration is economic development. The Navajo Nation has a large workforce, rich natural resources and a sophisticated, three-branch government. However, there are a variety of obstacles -- endemic to investing on reservations -- that have prevented the Navajo economy and other Indian country economies from getting their fair share of the business and jobs in this country.

First and foremost is the lack of infrastructure. For example, we have only 2000 miles of paved roads on the reservation itself. In contrast, West Virginia, which is roughly the same size as the Navajo reservation, has approximately 18,000 miles of paved roads. Many of the dirt roads on which our people heavily depend are simply impassible when the weather is bad. Even something so basic as telephone service is lacking in Indian country; over half of all reservation Indian households lack basic telephone service.

Another disincentive to economic development is the growing problem of "double taxation," wherein states increasingly are assessing taxes on non-Indian business activities permitted by, and occurring wholly on, Indian lands. As I explained to House Ways and Means last July:

> This double taxation interferes with our ability to encourage economic activity and to develop effective revenue generating tax programs.

* * *

> We find it especially hard to attract business to the reservation unless we make concessions that nearly defeat the purpose of wanting to attract business to the reservation in the first place.

These infrastructure deficiencies and other problems lead to the same result nationwide -- Indians do not compete on a level playing field with even the most economically distressed non-Indian areas and, as a result, are typically left behind, or left out altogether, from economic development opportunities. To help level that playing field, and to provide tribal governments and Indian country business planners with additional tools to compete, the Navajo Nation believes that new approaches must be tried.

Navajo Nation Tax Incentives Proposal

In particular, the Navajo urge that federal fiscal policy recognize the need to provide the private sector with incentives for investing in job-creating ventures in Indian country. The Navajo Nation believes that federal tax incentives are the mechanism for such a new approach, and that **this year's tax bill** is the perfect vehicle.

There are many reasons why tax incentives make sense. For example, in those same Ways and Means hearings last July, Senator Inouye was joined by Senator John McCain, Co-Chairman of the Select Committee on Indian Affairs, who explained:

> I believe for several reasons that a strategy of tax incentives . . . is the most effective way that the federal government can act to stimulate reservation economic development. Tax incentives do not depend for their effectiveness on the actions of federal bureaucracies that are often slow moving and unimaginative. The incentives are usable only by viable businesses that expect to earn some profits and hence to have tax obligations against which credits and deductions can be used to diminish their tax obligations. The federal government therefore does not spend anything until a real business is created on a reservation and there exist real jobs and real income generated for the benefit of reservation residents. Unlike direct spending programs, if there is no benefit, there is also no cost.

In other words, tax incentives of the type that the Navajo propose only cost the Federal government if they work, in which case they will be inducing the type of economic activity necessary to attack the deplorable unemployment situation in Indian country.

First, the Navajo Nation proposes an **investment tax credit** ("ITC") targeted to Indian country. This so-called "Indian reservation credit" is geared specifically to reservations where Indian unemployment levels are unconscionable -- **the credit being limited in its applicability to reservations having an unemployment rate exceeding the national average by at least 300%.**

The Indian reservation credit offers a higher percentage credit for investment in Indian country than would otherwise be available under a nationwide ITC, should one be adopted. No matter what type of tax strategy is ultimately adopted, this type of differential for Indian country is absolutely essential in order to help mitigate those unique problems associated with investing in Indian country -- particularly the lack of infrastructure -- which are not commonly shared by other economically depressed areas. Without such a differential, an ITC (or, for that matter, any other tax incentive that might be made applicable to both Indian and non-Indian lands) would essentially be useless for reservation economic development. This is so because Indian country -- both historically and at the present time -- cannot successfully compete with other areas in attracting business due to double taxation, infrastructure deficiencies and related problems.

Second, the Navajo Nation proposes an **Indian employment credit** aimed at increasing employment of Indians on reservations. A 10% credit to the employer would

apply to qualified wages and qualified health insurance costs paid to an Indian. An added incentive -- a significantly higher credit -- would be available to reservation employers having a workforce with at least 85% Indians. The credit, which focuses on job creation, would be allowed only for the first seven years of an Indian's employment.

The Navajo proposal is a modest, workable measure. If these incentives work, it is likely that increased Federal revenues from increased employment -- along with the anticipated decrease in public assistance payments -- should render these incentives, at worst, revenue neutral. A very credible analysis in support of this conclusion was issued in July, 1986, as part of the U.S. Department of the Interior's comprehensive, 265-page "Report of the Task Force on Indian Economic Development." The relevant excerpt from that lengthy Report is attached as an exhibit to my statement.

These complementary tax incentives are no panacea, and will not provide a quick fix to resolve our nation's staggering Indian unemployment problem. Other important actions -- such as improving Indian education and training -- need to be continued, and these are also high priorities of the Navajo Nation. However, this tax incentive proposal represents a constructive, meaningful step that can be taken in order to induce business to consider seriously the potential advantages to locating in Indian country.

Conclusion

Since 1970, the Federal government has pursued a policy of Indian self-determination, consistent with maintaining the Federal trust responsibility and the unique relationship that exists between Indian nations and the Federal government. While the Navajo and other Indian nations have made great strides along the path to self-determination, tribal governments will never realistically be able to achieve the goals of true self-determination without some measure of economic self-sufficiency on reservations.

The Navajo Nation and all of Indian country looks to this Committee because a new approach is needed to attract private sector investment and jobs to Indian country, and that new approach -- tax incentives -- falls within your jurisdiction. I want this Committee to know what our many friends on Senate Select already know -- that conditions on many Indian reservations are far worse than exist in many of the Third World countries to which our Government provides substantial foreign aid.

It is my understanding that an item on the Committee's agenda is to provide middle class tax relief. However, to put conditions in Indian country in perspective, on the Navajo reservation alone, 48.7% of all households have incomes below the poverty level. Thus, under circumstances in which Indians lack many of the items that most other Americans take for granted, meaningful measures to help bring investment and jobs to Indian country also address basic questions of human dignity.

Indeed, helping American Indians to help themselves is neither a Democratic issue nor a Republican issue; it's not a conservative policy or a liberal policy; it's not even a "special interest" issue. Rather, it is a "human" issue that must, and deserves to be, addressed from a **national perspective on a bipartisan basis,** and with a real sense of urgency warranted by the deplorable conditions existing in Indian country -- conditions which truly are a national disgrace.

I thank the Committee for its consideration, and I respectfully urge that the Committee include in the revenue package now under review the modest -- but extremely important -- tax incentives proposed by the Navajo Nation to promote economic development and jobs for all of Indian country.

THE
NAVAJO
NATION

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PETERSON ZAH
PRESIDENT

MARSHALL PLUMMER
VICE PRESIDENT

February 20, 1992

Delivered by Hand

Honorable Lloyd Bentsen
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I would like, first, to thank you and the other members of the Committee for granting me the privilege of testifying before the Committee yesterday in support of the legislative package being proposed by the Navajo Nation to help spur economic development and overcome the high levels of unemployment and poverty that exist on Indian reservations throughout the United States.

You will recall that, at the conclusion of my prepared statement, you asked me which component of our proposed legislation -- the investment tax credit or the employment tax credit -- we would prefer to see enacted if we had to make a choice between the two. My response to this most difficult question was that we would probably select the employment tax credit, my thought at the time being that the ultimate objective of our effort is to help put people to work.

I am very concerned, however, Mr. Chairman, that my response to your question could be interpreted to indicate that the investment tax credit component of our proposed package does not have the highest priority in Indian country. Nothing could be further from the truth. The two prongs of the Navajo proposal, supported by tribal leaders throughout this nation, were carefully crafted to complement one another. The principal thrust of the investment tax credit is designed to help level the playing field to attract businesses to Indian reservations, while the employment tax credit is principally designed to promote the employment of Indians by those businesses once on the reservation.

We strongly believe that each of these components, represent critical first steps to alleviate the terrible economic conditions that exist today in Indian country. The Study that I highlighted to you at the hearing indicates our proposals will have little or no adverse impact on the budget, when increased federal tax revenues and diminished federal public assistance payments are considered. It is clear, however, that without first being able to attract businesses to reservations, there can be no possibility of creating jobs. Accordingly, upon reflection, if we were told today that we had to choose between one or the other components of our legislative proposal, we would have to opt for the investment tax credit.

But you must understand - the Navajo Nation and Indian Country need both. The Indian Investment Tax Credit and the Indian Employment Tax Credit go hand-in-hand. We respectfully ask that you consider them as one. The budget impact is minimal, if at all.

I respectfully request that a copy of this letter be included in the hearing record.

Thank you again for your consideration of this legislation which is so important to our people.

Sincerely,

The Navajo Nation
Marshall Plummer
Vice President

PREPARED STATEMENT OF SENATOR HARRY REID

Senator Bentsen and Members of the Committee, thank you for the opportunity to testify here today on two issues that are very pertinent to these economic hard times this country is experiencing.

As one of our esteemed colleagues, Mo Udall, used to say, "Everything has been said, but not everyone has said it." (PAUSE) In the case of this recession, Mr. Chairman and Members of the Committee, I would say it is necessary for "everyone *to* say something." Until this country is once again on sound economic footing we need to hear all of the proposals and take action. The sooner the better. The American people deserve no less.

Two bills that I have introduced will make a significant contribution to resolving our economic woes. The first bill is S. 267, commonly referred to as the "Source Tax" bill. In fact, Mr. Chairman, last June I testified before Senator Boren's Subcommittee on Taxation regarding this very subject.

The problem is this. Nevadans, and citizens in every state, who are retired, and on fixed incomes, are forced to pay taxes to states where they do not reside. The retirees pay taxes on pensions drawn in the states where they spent their working years, despite the fact that they are not present to participate in the programs which their taxes are funding. They do not participate in medical assistance programs, senior centers, public parks, or, for that matter,they don't even get to vote in their former state of residence. Yet they still pay taxes to these states. In other words, Mr. Chairman, taxation without representation.

All too frequently, retirees are unaware that they must pay a tax to the state from which they draw a monthly pension check. Many people plan retirement in states with low or non-existent income tax and spend or save accordingly. Notifications that back-taxes and penalties are owed to a state other than the state of residence are rightfully met with indignation and outrage. The indignation rises from the shock of post-revolutionary taxation without representation; the outrage rises from the inability to pay an enormous tax debt when one lives on a fixed income.

The source tax is affecting more and more Americans as economic times become tougher. As state budgets strain to meet increasing expenses, they become more creative in looking for revenues. The source tax is politically easy to tap because the people that are assessed cannot show their indignation at the polls.

In addition, the state where the retiree currently resides may be losing revenue. Many states offer a tax credit when their residents pay taxes to another state. While the state of residence provides the services, as well as the right to vote, that state is not collecting the revenues from the individual benefitting from the services.

To put a halt to this practice, I have introduced legislation prohibiting states from taxing pensions or retirement income of non-residents. Its that simple. There is virtually no cost to the federal government, and it will relieve the tax burden on retired persons who live on fixed incomes.

Mr. Chairman, the second bill I would like to bring to the Committee's attention is S. 1398, a bill which would restore the exclusion from gross income for contributions in aid of construction, or CIACs. It has been estimated that up to $2,000 could be saved on the cost of a home if utilities did not have to treat these contributions as income. In fact, several of the committee members are cosponsors of this bill.

When a facility, such as a house, school or government agency is being constructed, builders extend gas and water mains and electrical lines into their developments. They then turn this property over to the utilities without charge, or they pay the utilities to install the lines themselves.

Prior to the Tax Reform Act of 1986, these contributions, or CIACs, were not taxable as income. The CIAC was excluded from the utility's rate base for rate-making purposes. Further, since the utility was precluded from claiming either tax depreciation or investment tax credit with respect to the CIAC property, the CIAC had no effect on the utility's tax liability in the current or any subsequent year. Therefore, the federal income tax treatment of CIACs had no effect on rates charged to consumers.

The '86 law changed this by subjecting CIAC to tax as gross income. The intent was to place part of the new corporate tax burden on utilities. In fact, what happens is the utility passes the tax onto consumers which results in a detrimental effect on the utility, on the environment and on the cost of housing.

Mr. Chairman, as a result of the change to CIAC in the '86 law, CIAC contributors must now make a substantially larger contribution than has been made in the past to be reimbursed for the additional tax burden. The contributor must also reimburse the utility for the "tax on the tax" or "gross up," which may be as much as 70% above the original cost of the contribution.

Several things may occur as a result of this reimbursement. The contributor may try to avoid the whole mess by either; setting up their own utility, building individual wells and septic tanks or hooking into a municipal system which does not pay taxes. The first two alternatives can create environmental hazards. EPA says that over 90% of community water systems in violation of the Safe Drinking Water Act were made by systems serving less than 3,300 individuals.

However, probably the biggest drawback is the increase in housing costs that can result. The National Association of Home Builders has estimated the CIAC tax contributes as much as $2,000 to the price of a new home. This new cost comes at a time when housing starts are at their lowest level since 1946 and multi-family starts are the lowest on record.

Mr. Chairman and Members of the Committee, thank you for the opportunity to testify here today. Your interest in these issues is not only important to me, but important to people around the country. It is important to senior citizens who have a diminished buying power because of the Source Tax. It is important to those people who want to buy a new home but can't afford it due to additional costs such as the tax treatment of CIAC. So, I urge you to give these legislative proposals your attention and include them in the tax package you report.

PREPARED STATEMENT OF SENATOR CHARLES S. ROBB

Mr. Chairman, I appreciate the opportunity to testify before your Committee on one aspect of U.S. tax policy.

Almost two weeks ago, as part of the National Energy Security Act of 1992, the omnibus energy bill, the Senate adopted an amendment which I authored expressing the sense of the Senate that this committee and the House Ways and Means Committee should study the possibility of revenue neutral legislation which shifts some amount of taxation from income to motor fuels. I would like to take this opportunity to briefly explain the rationale behind the amendment and to offer some specific suggestions to the Committee.

Mr. Chairman, most Americans agree that conservation must be at the heart of any national energy strategy. Conservation of oil, in particular, reduces our reliance on foreign sources of energy, it is good for the environment, and it makes us more competitive as a nation. Through the U.S. tax code, the Congress, and this Committee in particular, has enormous power to help forge a bold and forward looking energy policy. By shifting some of the existing burden of taxation from income to the motor fuels pump, we can encourage Americans to buy more fuel efficient cars, to car pool, and to use alternative forms of transportation. Shifting the tax from income to motor fuels would save millions of barrels of oil, unleash investment into alternative fuels, and reduce the risk of global warming.

I fully understand why people have shied away from this idea. Last month, I gave a speech at the College of William & Mary where I proposed imposing a conservation tax of 40 cents a gallon, phased in over three years, with revenue rebated to taxpayers in the form of a refundable tax credit. The banner headline in the local newspaper, of course, didn't get into nuances; it declared: "Robb favors 40-cent gasoline tax hike." The headline contained no mention of the three year phase in. Nor did it make reference to the fact that I proposed returning every penny of the revenue through a tax credit. It just read: "Robb favors 40-cent gasoline tax hike."

The reaction has been, as I expected, fairly negative from some corners. The Petroleum Marketers Association of America is opposed, as is AAA and the American Petroleum Institute. (This all lead to another wonderful headline: "Robb's gas tax idea blasted.")

But I also detect an openness to the proposal, which I think stems in large part from the realization that, following the Persian Gulf War, we are a different nation than we were before it. The American public is now all too aware that our reliance on oil, Middle Eastern oil in particular, has certain very real costs associated with it. Our intervention in the Persian Gulf was not predicated specifically on oil, it was about defending the victims of aggression and upholding international law. But oil was always a major factor in that involvement, and those supporters of the war who denied it helped foster an equally false backlash which said the war was *only* about oil.

The truth, of course, is that we fought Saddam Hussein because both our principles and our national interests were at stake. The Carter Doctrine recognized that because oil lubricates the economies of the Western world, we have a national interest in protecting its free flow. Those who opposed the war were correct when they said that we would not have put 500,000 troops in the Gulf if Saudi Arabia's main

export were kiwis. And I don't think the public will stand for attempts to gloss over our energy dependence.

For constitutional and jurisdictional reasons, I could not, of course, have offered an actual tax amendment to the energy bill, but I did want to raise the issue then—as I am again today—because I don't think it makes sense for us to be talking about forging a comprehensive energy policy without saying a word about what many observers believe is the single most important step available to reduce our reliance on imported oil: increasing the motor fuels tax. In my William & Mary speech, I talked about increasing the tax 40 cents over a three year period: a nickel increase in the first month followed by a penny a month thereafter. The resolution adopted by the Senate does not specify an amount, but urges this Committee to look into the matter to see what an appropriate increase would be.

The resolution stipulates that any increase in the gas tax should be offset by an across-the-board tax cut. I personally would prefer that the money generated by a conservation tax be used to reduce our federal deficit, to rebuild our infrastructure, and to boost the earned income credit for the poor, to counteract the regressive nature of the gas tax. But that approach would have meant a net tax increase on the American public. And as the recent experience in the House of Representatives suggests, a gas tax increase without a corresponding rebate is dead on arrival.

The tax credit could be fairly significant after three years, depending on the size of the conservation tax. If this committee chose a 40 cent per gallon increase, for example, that would mean a tax credit of $215 for individuals and $431 for married couples filing jointly—according to Joint Tax Committee estimates.

Because the wealthy consume more gasoline per household than the poor, a program which rebates an equal amount to all taxpayers would actually be *more progressive* than the current tax structure. And unlike the proposal to boost national security by drilling in the Arctic National Wildlife Refuge, the gas tax unites environmental and national security interests: conserving energy and moving toward alternatives to oil means less pollution and greater security. In particular, increasing the motor fuels tax will result in a sharp reduction in carbon dioxide emissions, a major contributor to global warming.

Mr. Chairman, I realize that shifting taxation from income to motor fuels will be seen by some as risky politics. I've been told that the American people won't be able to understand such a proposal—that they'll hear gas tax but won't hear about the offsetting rebate. That they'll talk about patriotism but won't want to do anything to prevent threats to our national security.

I give the American people more credit than that. They know the ultimate sacrifice paid by those in the Persian Gulf War by the soldiers and their families. They know that we should not continue to send dollars to the likes of Saddam Hussein so that war machines—and nuclear capabilities—can be built and resurrected. They know that we have had three energy crises in the past 15 years, and that each time, there has been a brief flurry of activity, but that only the easy options have been pursued.

I realize that the Congress has in the past rejected attempts to significantly increase the motor fuels tax. In 1979, Rep. John Anderson proposed increasing the tax by 50 cents and rebating the revenue through the social security system. In that same year, our distinguished colleague, Senator Johnston, introduced legislation to increase the motor fuels tax by 50 cents over five years and directed the states to rebate the revenue in reduced sales, property or income taxes, or to use the money for mass transit. Neither proposal was adopted.

In the past, rather than increase the gasoline tax, the Congress has chosen other alternatives, such as increasing corporate average fuel economy. Because CAFE legislation provides an incentive for auto makers to design more fuel efficient vehicles, I am a supporter and cosponsor of the Bryan bill. But boosting the fuel economy of cars and trucks only gets you so far. CAFE standards affect only new vehicles (which account for 10% of fuel consumption), whereas a gas tax increase encourages conservation among all drivers, whether their cars are new or old. And by increasing fuel economy, CAFE standards actually made it cheaper for drivers to drive more, which dilutes the effect of the measure. Nevertheless, the CAFE alternative was pursued over proposals to impose a conservation tax because the conventional wisdom precludes having anything to do with a gas tax—and I confess it's hard to see how there's any political mileage in the approach I'm advocating.

Still, it's clearly right as a matter of public policy, and I think the political climate may have changed somewhat since the earlier attempts to raise the gas tax—for three reasons.

First, as I've mentioned, the American public knows the cost of oil dependence now that we've gone to war in large part over oil. There had always been warnings that given the strategic importance and scarcity of oil, and its concentration in the

most volatile part of the world, that nations would one day go to war over oil. In the late 1970s, our dependency cost us jobs; in the early 1990s, it cost us lives.

Second, gasoline prices in real terms are now at their lowest point in decades. Oil is selling as low as $17 a barrel. Adding a conservation tax now would not be a "piling on" on top of natural price increases, as it was in the late 1970s.

Third, environmental awareness is much greater today that it was a decade and a half ago. We now know much more about the dangers of global warming. Each gallon of gasoline used produces 18 pounds of carbon dioxide, a key "greenhouse" gas. We now know that more than 100 of our cities violate federal clean air health guidelines. Pollution problems have grown worse, and the American public has awakened to the dangers. The environmental community is now a political force to be reckoned with as we saw when the Senate failed to invoke cloture last year on an earlier version of the energy bill.

But even if the politics are against the idea, I believe strongly that we need to seriously consider it. Repeatedly, when I discussed the pending energy legislation with individuals, whether they came from the environmental community or the business community, they told me that the best thing we can do to address our dependence on foreign oil is to increase the gas tax. While there are no true silver bullets for our energy problem, I've been told that adding a conservation tax was the closest thing we'll ever come to one. And then, in the next breath, they invariably told me that, of course, the gas tax alternative will never pass the Congress. I find that very disturbing.

I realize that opponents of the conservation tax have many concerns. Opponents could say it's regressive, and unfairly hits those in the West; that it interferes with the free market, will hurt our competitiveness, and will hurt growth. But, Mr. Chairman, I think that your committee's exploration of this issue will show that there are very good answers to each of these objections.

In closing, Mr. Chairman, I look forward to working with you and other members of the Senate Finance Committee on the conservation tax in the coming weeks. As someone who represents a state which disproportionately provides troops in times of war, I can't—in good conscience—ignore a sound proposal which is seen by so many as a key to addressing our overreliance on imported oil.

PREPARED STATEMENT OF SENATOR JOHN D. ROCKEFELLER IV

Thank you, Chairman Bentsen, for holding this very important hearing this afternoon on President Bush's proposed fiscal year 1993 budget for the Department of Health and Human Services. while I am pleased that the President and I share many similar priorities, such as childhood immunizations, WIC, community health centers and the National Health Service Corps, I am less than pleased that when one carefully scrutinizes and reads between the lines, some of these increases are really not as they appear.

In comparison to Medicare and Medicaid cuts proposed in the past by the Bush Administration and the Reagan-Bush Administration, $1.3 billion in Medicare cuts appears modest. If one forgets that this would be on top of almost $9 billion in cuts already included in the OBRA 1990 five-year budget agreement for fiscal year 1993.

Just as I was opposed to last year's proposal by the Bush Administration to cut another $2.8 from Medicare—on top of the almost $4.0 billion in Medicare cuts already slated for fiscal year 1992—I remain extremely skeptical of Medicare cuts that are proposed not on the basis of sound health care policy, but rather as an arbitrary way of reducing Medicare payments for budget scoring purposes. For example, delaying the hospital update from October 1 to January 1 is purely an accounting ploy, yet another budget gimmick.

I also have many questions about a proposal outlined in the Bush budget that would place an arbitrary cap on all mandatory entitlement programs. This type of scheme would lower federal costs for our two major health care programs, Medicare and Medicaid, by, in effect, converting Medicare and Medicaid into block grant programs. Under this proposal, costs of providing health insurance to low income families would merely be shifted to the states—who are already drowning in red ink—and would seriously harm access to health care for seniors and the disabled by slashing hospital and doctor reimbursement rates.

Instead of providing national leadership and national solutions to deal responsibly with rising health care costs, this Administration is essentially telling states, the disabled, and senior citizens to go it alone.

When it comes to talking about restraining double-digit medical inflation and trying to help businesses and families afford health insurance, this Administration uses scare-mongering tactics and talks about rationing, waiting lines, and federal

government ineptitude. Frankly, I think Secretary Sullivan does a pretty good job, given his tight budget, of administering the Medicare program. I'm surprised that I have heard so many Bush Administration officials predict lately that a government-run health care program, like Medicare, would have the compassion of the IRS and the efficiency of the U.S. Post Office.

Secretary Sullivan, I hope you can explain this dichotomy to me today. For senior citizens, the disabled, and the poor, this Administration has arbitrary cuts and caps. But for the rest of this country, it's business as usual.

Under a bill I have introduced with two of my colleagues on this Committee, Senator Riegle and the Majority Leader, Senator Mitchell, we have proposed the establishment of a Federal Health Expenditure Board, composed of private citizens, that would set national targets for health care spending and would oversee negotiations between hospitals and doctors and those who pay the health care bills.

This is not government rate setting. Nor is it the imposition of an arbitrary cap, such as the one outlined in the Bush budget, which is a mathematical formula designed to artificially hold down health care costs rather than a formula based on human needs and appropriate use of health care services. Rather, we have proposed a framework for the private health care sector to come together and sit down at a rather large table to try to restore rationality to our health care reimbursement system.

Thank you and I am looking forward to hearing from Secretary Sullivan and our other witnesses today.

PREPARED STATEMENT OF SENATOR WILLIAM V. ROTH, JR.

Thank you Mr. Chairman. This Committee has held a series of hearings on the nation's health care crisis and I believe that today's hearing to examine what has been put forth by the Administration will continue to help us in reforming the health care system.

While I believe that the President's FY93 Budget proposals for health care present us with a good working document, I do have several concerns with some of the provisions. Of the proposed reform, I do support the efforts to expand preventative care and to encourage the development of managed care networks.

However, I do not support the provision to means test the Medicare program. In my view, during the debate on Catastrophic Insurance we already travelled down that road and it was proven not to be acceptable to Seniors.

Also, I have had an ongoing interest in improving the recovery of payments under the Medicare Secondary Payer program (MSP).

I have introduced legislation (S. 365) similar to what the Administration was interested in last year's budget proposal. Having received comments from the Administration in support of my bill, and since the proposal was not mentioned in this year's budget I am presently interested in learning whether there is ongoing support for my type of proposal.

The entire health care system is skewed. The health care market has delivered this nation the best quality health care in the world, yet costs are running rampant and millions do not have access to routine medical treatment.

Today, we are faced with a highly complex system where the patient can not figure out how to make cost conscious and quality conscious decisions about his or her health care, and the insurance industry is no longer willing to assume the risk of covering unhealthy individuals.

The high number of uninsured individuals and the high cost of health care are interrelated problems that have aggravated the distortion in the health care system. Each time services are provided to a patient with no insurance or the ability to pay, the costs are passed on to those who can.

The insurance industry responds with increased premiums and exclusion from coverage for some high cost and pre-existing conditions.

As insurance premiums increase, more individuals and businesses drop their coverage and join the pool of uninsured. Instead of striking cost containment agreements with providers, the insurance industry has progressively gotten out of the business of assuming underwriting risks by no longer assuming the insurance needs of potential losses such as the very sick, disabled, or other high risk individuals.

Because the system is void of price competition, this vicious cycle is now an inherent part of the current health care crisis.

We are all familiar with the numbers on health care spending in the nation. We spend more than every nation on health care, in the aggregate, per capita and as a percentage of GNP. Yet, there are 35 million individuals with no insurance. These numbers clearly indicate one fact our health care crisis is not being caused because

we are not spending enough money—it's how we spend the money that should be changed. Reform of the health care arena needs to be achieved, however, controlling the escalating costs must be part of our solution.

Prepared Statement of Gary Stangler

INTRODUCTION

Mr. Chairman, members of the Committee, I am Gary Stangler, Director of the Missouri Department of Social Services and Chairman of the Health Care Committee of the American Public Welfare Association. I appreciate the opportunity to speak today about the Bush Administration's Fiscal Year 1993 budget proposals and the President's newly released health care reform proposals.

THE FEDERAL BUDGET PROPOSALS FOR MEDICAID

The administration's proposed budget highlights the fact that the Medicaid program continues to grow at a phenomenal rate. The rate of growth is of increasing concern to states and the federal government which share in the cost of the program.

State Medicaid expenditures have increased by an average of 20 percent over the past two years. By the end of this federal fiscal year, the Medicaid caseload will have grown 28 percent since 1989—a dramatic change relative to other periods. Medicaid is expected to serve 30.1 million people in FY 1992, up from 23.5 million in 1989. Total state and federal expenditures for FY 1992 are expected to reach $127.2 billion, and grow to $148 billion during FY 1993. States are finding that this rate of growth is almost impossible to sustain in the current economic climate.

In order to reduce federal Medicaid expenditures the administration has proposed several program changes, one of which causes great concern to state agencies. This proposal would charge all facilities for the costs of certification necessary to participate in the Medicaid and Medicare programs. According to the administration, this would save an estimated $99 million in FY 93 federal Medicaid costs. Essentially, however, the proposal amounts to little more than a cost-shifting of federal costs to the states. State-operated facilities like intermediate care facilities for the mentally retarded would likely have to pay these costs, representing a direct cost shift. If the fees were allowed as a Medicaid-reimbursed cost for facilities, state Medicaid funds would then subsidize the cost of federally-imposed fees, which is an cost-shift. State agencies simply cannot afford such cost shifts when they can barely sustain current services. This proposal has been put forward in the past and states have opposed it, and will continue to do so.

The budget also proposes to save $5 million by making changes to Medicaid Third Party Liability (TPL) requirements. State agencies support improvements to TPL as a method to increase program offsets. We would urge, however, that Congress look to enact proposals that increase state effectiveness without increasing already overburdened state administration. APWA has worked closely with state agencies over the past two years to develop a series of proposals that are viable and cost-effective—and will, we believe, generate more than $5 million. These are proposals the states know will work and will not require lengthy implementation and I would urge you to work with the states and APWA to enact these proposals this year.

State officials believe it is time to simplify the Medicaid program—both in terms of eligibility ad administration. Again, APWA has worked closely with the states to develop a series of proposals that, while relatively small in scope, will simplify eligibility and thereby improve client access while easing the substantial administrative burden of the states. We urge this Committee to consider these proposals this year.

In the area of administrative simplification, APWA strongly supports the legislation introduced by Senators Chafee and Riegle and their colleagues to provide vitally needed changes in the Medicaid audit and disallowance process. The legislation would also permit a greater focus on issues affecting both quality of care and efficient administration. Again, we strongly urge consideration of this bill, S. 1240, this year.

The administration's budget indicates a new attitude toward granting waivers of federal program requirements in order to permit state innovation with strategies aimed at broader coverage of the uninsured and underinsured. States have encouraged this type of change for some time. A willingness to expedite review and approval of state waiver requests will encourage states to move forward with innovation.

I believe state agencies would generally agree that the President's health care reform proposal is important. At a minimum, it signals that the Administration is now ready to engage in the important debate on health care financing. Administration participation in the debate will surely help move the discussion forward. The American Public Welfare Association has published its own health care reform proposal to assure improved coverage and access to care for the uninsured by increasing both private and public sector responsibility. Given my role as a state human service administrator with responsibility for the Medicaid program, I feel it is appropriate at this time to address those aspects of the proposal that affect Medicaid. I also must add that all states have not yet had time to review the specifics of the President's full proposal. I am aware, however, that different states have different views of the proposal.

Some states will be concerned about the proposed conversion of fee for service Medicaid to a waiver service. There are states, particularly rural states, in which managed care has not yet been developed as an option. To put the only available system, fee for service, under a waiver would thus be very problematic. Coverage of severely disabled and medically needy clients in managed care also has not been possible in some states, necessitating the continuation of fee for service without waivers. At the same time, the proposal to make managed care a regular state plan option would be supported by a number of states. There are several states (MI, AL, WVA, NY and AZ among others) that have, or will soon have, statewide Medicaid coordinated care. For these states, the proposal will have clear benefits, as it will for other states that are not yet able to go statewide but are anxious to do so.

One possible compromise between mandating managed care in Medicaid and continuing the status quo would be to enact the legislation sponsored by Senators Moynihan and Durenberger. This legislation, S. 2077, would make coordinated care a regular state plan option. Under this bill, development and expansion of coordinated care would be facilitated by removing the need for waivers. The bill also strengthens quality assurance requirements and would allow states to move to coordinated care at their own pace. This bill has gained the endorsement of APWA's National Council of State Human Service Administrators.

In terms of the administration proposal to limit federal Medicaid expenditures, there is concern among some state agencies about whether cost increases could be kept to a level just above general inflation, even with some type of coordinated care—especially in the short run. For example, primary care case management programs are typically fee for service systems, although they are systems of coordinated care. Fee for service will still be subject to inflationary pressures even with a federal expenditure limit. Even risk-based, capitated systems will have to reflect changes occurring due to successful hospital reimbursement lawsuits, increasing costs of pharmacy programs, and upward pressure on individual provider rates. A state's ability to contain costs and slow the rate of increase will in some measure depend on its current level of reimbursement to facilities and individual providers, and the amount of upward pressure on those rates. In addition to payment levels, many states are in the process of expanding their programs and would be penalized by a payment base established while expansion is still in progress. Further, states should not be penalized by denial of federal funds if excess cost increases occur that result from factors beyond the control of the state. If federal expenditure limits were to be established, then state programs would have to be given greater statutory authority to control program costs.

The need for greater program flexibility would also apply to the proposal to allow states to combine the Medicaid program and the proposed health voucher system into one program for all individuals below the poverty level. This option, presented in the proposal, would be welcomed by some states that have been searching for innovative ways to provide broadened coverage for all uninsured poor people and who believe that developing a unified system to do so is the most efficient way to proceed.

SUMMARY

APWA urges this Committee to work with states to improve the current Medicaid program while health care reform continues to be debated. We would request that members seriously consider proposals to improve third party liability, eligibility, audit and disallowance reform, and managed care. Many of these proposals are cost neutral or will generate savings without adversely affecting clients.

In terms of health care reform, we would urge this Committee to continue its efforts to develop a consensus. With regard to the specific proposals put forward by the administration, we believe common ground can be found so that states are en-

couraged to develop innovative coverage and service delivery models yet are not penalized if, for whatever reason, they are not yet prepared to move forward with sweeping reforms. The process should be used to develop a consensus on what constitutes effective cost containment.

APWA remains ready and willing to work with Congress and the administration to reform the current Medicaid program and to devise a sound strategy for broader health care reform. We believe that the considerable state experience in cost containment, administrative efficiency, and meeting very diverse needs within one program, can be a vital source of assistance as the debate on reform moves forward.

Thank you for the opportunity to testify today.

PREPARED STATEMENT OF LOUIS W. SULLIVAN

Mr. Chairman and Members of the Committee: Thank you for the opportunity to appear before you to discuss our budget proposals for the next fiscal year. I also want to express my appreciation to you for accommodating my schedule so that I can appear here today.

Health and human service issues are of paramount interest to the Members of this Committee and the American people. I am of the strong opinion that all the programs that we forge as government officials should be "family friendly." As we all recognize, the family is the first and most effective health and human service organization

I firmly believe that both the President's budget proposal and his health plan that he unveiled on February 6 are "family friendly." The budget addresses the real needs of the American family—particularly our children. And our health plan provides families the peace of mind that they will have health care coverage when they need it. Each of the President's health care proposals make a contribution toward affordability of insurance, slower growth in costs, improved access, continuity of care, and the security of health insurance.

I realize that, together, we will be continuing the dialogue on health care reform in the weeks and months ahead. But, I want to underscore my belief that the President transformed the nation's debate about health care this month with the presentation of his plan. And the stakes in this debate are high. Will we increasingly turn to government, subjecting our health care sector to the whims and vacillations of Federal budgets and bureaucrats? Or will we maintain our mixed private/public system, drawing on the best in strengths of the private market?

I put my faith in a system that bears the label "Made in the U.S.A"—the President's plan—which provides efficient and affordable care, wrings out excess and waste and controls federal growth. This plan is a practical one based on what works and contains innovative approaches such as those found in the Bentsen-Durenberger and Chafee small market reform measures. The President's plan will give American families the kind of health care they want and deserve and puts an end to the worry that keeps them up at night.

Before taking your questions, I would like to briefly review a few of the highlights of our budget proposal: Our budget has a particular emphasis on the well-being of children—especially children at risk of long-term dependency and poor health. The 1993 budget for HHS includes some $76 billion for health and welfare programs benefiting children, with an increase of almost 10 percent from 1992. This includes discretionary programs such as Head Start; and entitlement programs, such as Aid to Families with Dependent Children, Medicaid, and the Social Security program. For 1993 alone, we propose an increase of $600 million for Head Start, the largest ever made—and an increase of $4.4 billion for child health programs.

- In Head Start, funding will more than double in the four years from 1989, and enrollment will increase 73 percent. The funding level proposed for 1993 will mean that every eligible child whose parents want them to, will be able to receive a Head Start experience for one year before entering school.
- For child and maternal health, Medicaid funding will increase by $4.2 billion, to more than twice the level of four years ago. And public health services for children will increase by $200 million in 1993. That includes $79 million more for the Healthy Start program, which is targeted to high-risk areas to cut infant mortality in half.

We are continuing to make improvements in the Family Support Act, a landmark law which was in large part the product of the work of this Committee. All 50 States now have JOBS programs in place, to provide training and work opportunities to AFDC recipients to assist in achieving self-sufficiency. In addition, States

have been aggressive in implementing the child support enforcement provisions of the statute.

Our budget calls for two important modifications in the Aid to Families with Dependent Children Program (AFDC). One proposal would give States the option to raise the asset limit for AFDC recipients to $10,000 from the current $1,000 level. These savings could be used to improve the education, training or employability of a family member, or to purchase a home.

Another proposal would allow States to promote entrepreneurial activities among AFDC recipients by developing self-employment plans and excluding all income and resources related to such plans. These proposals will provide additional approaches to encourage low-income Americans to move toward self-sufficiency. That is the essence of the American dream, and it should be within the grasp of all citizens.

To help States provide our children with quality services, we are proposing to change the financing of State child welfare activities to allow States greater flexibility in meeting the needs of all children in crisis. The new Comprehensive Child Welfare Services capped entitlement program would be funded at $1.3 billion in FY 1993 increasing to $2.2 billion by FY 1997.

We in government have a role in helping our children and families, but there is simply no replacement for personal responsibility. Fathers abandoning their children, violence on the streets and poor health habits cannot be combatted by merely adding more to a government authorization or appropriation. These problems can only be truly tackled by individuals taking responsibility for their actions. I call it building a "culture of character." To draw from the wisdom of that trenchant social philosopher, Barbara Bush, "What happens in your house is more important than what happens in the White House."

We know, for instance, that there is a distinct connection between children in poverty and single-parent families. Children missing a parent are more vulnerable: they are five times more likely to be poor and twice as likely to drop out of school as children who live with both parents. In any given year, nine out of ten children from two-parent families avoid poverty, but one out of two children living in female-headed households are poor. In fact, the increase in the proportion of mother-only families accounted for about half of the overall increase in child poverty from 1979 through 1987.

Clearly, government has a role in addressing this problem—through such programs as child support enforcement—but without parents—fathers in particular—assuming parental responsibility for their sons and daughters—too many children will continue to suffer both economically and emotionally. We must, as a nation, recapture the spirit of family that nurtures, protects, and strengthen our children. We have no more important task than that.

In closing, I look forward to working with the Members of this Committee in forging a budget and reforming the health care system in a way that puts families first. That, I believe, is our charge from the American people. Thank you, and I welcome your questions and comments.

Attachments.

Responses of Secretary Sullivan to Questions Submitted by Senator Grassley

Question No. 1. Would it not be reasonable to assume that, even if we completely reorganize our health care system, we could continue to experience very high health care costs unless we make better progression individual behavior or the social dimension of the problem?

Answer. Both the President's plan and I have made very clear that success in containing health care costs will depend very greatly—although not exclusively—on the behavior of health care consumers.

The harsh truth is that a high percentage of the disease and disability afflicting the American people is a consequence of unwise choices of behavior and lifestyle. The most significant things we can do to reduce health care costs are within our control: get enough sleep, exercise, stop smoking, eat a balanced diet, drink moderately, and avoid drug abuse.

For example, an estimated 18.5 million Americans abuse alcohol and may become candidates for a $250,000 liver transplant. The health costs of alcohol abuse are staggering. The U.S. has about 375,000 drug exposed babies. Estimated five-year costs of treatment are $63,000 per child. Adequate nutrition and regular exercise may be less dramatic but highly effective in helping control costs. The incidence of diseases such as cancer can be reduced with adequate fiber content in the diet and the risk of heart attack can be moderated if cholesterol levels are lowered.

Question No. 2. We head a lot in the reform debate about the wonders of the health care systems in other countries and how much better they are doing than we are in controlling health care costs and in getting better results.

But do we have any systematic analysis of how the united states compares with these other countries with regard to social behavior?

If not, without this kind of comparative baseline data, do these international comparisons that show other countries getting better results than we do really mean anything?

Answer. Direct comparisons of U.S. health costs and outcomes with OECD nations can be misleading because of exacerbated social problems in the U.S. which have significant health costs and adversely affect U.S. health outcomes.

The 20,000 annual U.S. homicides result in per capita homicide rates 10 times those of Great Britain and four times those of Canada. Homicide is the leading cause of death for blacks between 15 and 44; the rate for black males was more than 8 times the rate for white males of the same age.

There are 100 assaults reported by U.S. emergency rooms for every homicide. About 25 percent of spinal cord injuries result from assaults, and lifetime care for a quadriplegic average $600,000.

U.S. child poverty rates are double those of West Germany and Canada and triple those of Switzerland and Sweden.

The U.S. has had a total of 206,000 AIDS cases; there were 39,000 AIDS deaths in 1990 alone, reflecting an AIDS infection rate four times that of Canada. The average lifetime health costs of an AIDS patient are now $85,000; these costs may increase as new drugs are developed to prolong the life of AIDS patients. AIDS is putting budget pressures on inner-city hospitals and emergency rooms because many AIDS patients do not have adequate insurance. Recent studies estimate that the U.S. will spend $5.8 billion caring for AIDS patients in 1991 and that these costs will rise rapidly to $10.4 billion by 1994.

Although this evidence is not as systematic as we would like, it is clear that the social problems in the United States contribute significantly to our higher health care costs.

Response of Secretary Sullivan to a Question Submitted by Senator Mitchell

Question. Mr. Secretary, as you know, Medicare payments for the interpretation of EKGs was eliminated on January 1, 1992. There is pending broadly supported legislation in both the House and Senate to reinstate payment for the interpretation if EKGs. Could you comment on the Administration's position on this issue?

Answer. We do not object to the proposal to reinstate separate Medicare payment for interpretations of EKGs as long as it contains language that the change in current law would be accomplished by a fully offsetting—including added administrative costs—reduction in aggregate payments for physician services under the Medicare fee schedule.

Responses of Secretary Sullivan to Questions Submitted by Senator Rockefeller

Question No. 1. The Fiscal Year 1993 budget of the President reduces current spending for the PRO program to $272 million dollars. Please explain this reduction in PRO program expenditures in light of the Institute of Medicine recommendation to double the budget of Medicare quality oversight activities in its congressional report, Medicare: A Strategy for Quality Assurance?

Answer. The Fiscal Year (FY) 1993 President's Budget includes a Department General Provision limiting peer review organization (PRO) obligations to *$489 million* in 1993, not $272 million. We currently expect to spend less than this OMB-approved limitation in FY 1993. The limitation on spending will have no real impact on the PRO program and was designed to score discretionary outlay savings. In fact, the $489 million is more than twice the estimated total FY 1992 PRO obligations.

Question No. 2. What is the aggregate DHHS spending authority for the PRO program in the next round of three year PRO contracts (fourth contract cycle)?

Answer. During the fourth round of PRO contracts, we will implement the Health Care Quality Improvement Initiative. The central points of our initiative will be physician participation in the analysis of patterns and outcomes of care; providing feedback to the health care community and to the consumers; and monitoring the effectiveness of these activities. OMB has apportioned $892 million for the next three years of PRO activities; $168 million for third round extension contracts and related activities and $724 million for fourth round contracts.

Question No. 3. What are the Department's plans for implementation of the Uniform Clinical Data Set in the PRO program? Please describe, in detail, the results of the pilot testing of UCDS in the six PRO sites?

Answer:

- Six States are currently involved in the UCDS System (UCDSS) project.

CO expires 9/30/92	WI expires 3/31/93
UT expires 9/30/92	AL expires 3/31/93
IA expires 3/31/93	CT expires 3/31/93

- UCDSS is under a continuous quality improvement process. We have a number of workgroups in place and new software is released about once per quarter. There are 3 workgroups which involve staff from the PRO pilots: Algorithm Refinement Project, Data Entry Workgroup, and Data Workgroup.

PHASE I

Phase I involved a 6 percent sample of inpatient hospital cases sampled between February and June 1991. For each case both the UCDSS and traditional review was performed. Although not necessarily statistically significant, this is how traditional review compared to review under the UCDSS in terms of referral rates, denial rate, and confirmed quality problems rate:

(1) **Referral rates** are higher under UCDSS.
Traditional review has a 42 percent referral rate versus 51 percent under UCDSS. If we include cases approved by UCDSS but referred by the nurse, there is a 56 percent referral rate under UCDSS.

(2) **Denial rate** is higher under traditional review.
Traditional review has a 1.1 percent denial rate. UCDSS has a 0.8 percent denial rate. If nurse overrides are included, UCDSS has a 1.0 percent denial rate.

(3) UCDSS has a higher **confirmed quality problems rate** than traditional review with greater numbers of confirmed problems in the higher severity levels.
Traditional review has a 1.5 percent confirmed problem rate. UCDSS has a 1.7 percent confirmed problem rate. If nurse overrides are included UCDSS has a 2.6 percent confirmed problem rate.

PHASE II

Phase II of UCDSS implementation began in September 1991 and consists of a 10 percent beneficiary sample. Results of this review are not yet available.

However, we have been monitoring the 6 PROs to determine how they are performing. Three PROs are experiencing workload problems. These are Connecticut, Wisconsin, and Utah. We are especially concerned about Utah which has a backlog of 54 percent of the sampled cases and has spent 85 percent of the contract funds.

PRO pilot state	Backlog percent	Months left in contract	Level of expenditures percent
Alabama	31	8	51
Colorado	17	2	62
Connecticut	49	8	40
Iowa	9	8	32
Utah	54	2	85
Wisconsin	62	8	51

All pilot PROs have the same abstraction responsibilities. There is no apparent reason for the abstraction workload to be more or less difficult or labor intensive in one State than in another. The process or structure of the production process is the most probable explanation of the differences in productivity and costs. Each of the PROs is able to structure their production process as they chose.

Question No. 4. Please provide information on UCDS experience to date that justifies national implementation along the following measures: (1) it improves individual case review; (2) it is a tool that permits sophisticated epidemiological surveillance; (3) it is more cost efficient relative to traditional review technologies currently in place in the program.

Answer. The Uniform Clinical Data Set (UCDS) System will be implemented as part of HCFA's Health Care Quality Improvement Initiative.

The goal of this initiative is to move the PRO program away from reviewing individual clinical encounters and toward helping the health care community improve the mainstream of care.

We plan to use the UCDS system in two ways:

(1) As a tool to collect clinical data on thousands of hospital cases, which we and the PROs can use to epidemiologically analyze patterns of health care and patient outcomes.

Most clinical groups and experts in quality management agree that traditional review will never be capable of producing significant, measurable improvement in the quality of care delivered to Medicare beneficiaries. By contrast, use of pattern analysis will allow measurement of quality indicators. Efforts to bring care up to the standards laid out in patient care guidelines then promise measurable and substantial improvement in both care and outcomes.

(2) To select individual cases for medical review through the automated application of practice guidelines.

The six pilot PROs have been testing only the second approach. The detailed results of those case selections and the ensuing reviews are attached.

HCFA believes that the UCDS system should not be fully implemented until supported by thorough evaluation. We have revised our implementation schedule as a result of continuing discussions with the PRO, health care and consumer communities.

CLINICAL DATA ABSTRACTION

Initially, HCFA will have its Clinical Data Abstraction Contractors (CDACs) abstract into the UCDS only the medical records to support the Cooperative Cardiovascular Project, a special PRO pattern analysis and feedback project.

We are working closely with researchers and the medical community to refine the data elements collected by the UCDS, so that they will be adequate for (1) analysis relating patterns of care to patterns of outcomes and (2) assessment as to whether medical society-developed practice guidelines have been followed.

All PROs should be using the data from this project by the end of 1993. The database will include data for about 400,000 Medicare discharges a year: records for patients experiencing an acute myocardial infarction, receiving a coronary artery bypass graft or a coronary angioplasty.

Under the fourth Scope of Work, PROs will conduct traditional case review on about 600,000 records a year. This review will include screening of the records by nurses until our evaluations indicate that the UCDS system is ready to conduct case selection.

When evaluations are complete, we will work with the PROs to gradually reduce traditional nurse review and to make necessary preparations for new PRO responsibilities.

UCDS REFINEMENT STRATEGY

HCFA's UCDS refinement strategy includes collaboration with the PROs and the health care and consumer communities. Among the principal participants are: the UCDSS Pilot PROs, the American Medical Association (AMA) Practice Parameters Panel and the Agency for Health Care Policy and Research (AHCPR).

The UCDS system is being pilot tested by PROs in 6 States. We have asked the UCDSS Pilot PROs to identify all instances in which the physician reviewer or clinical data abstractor identifies an apparent error in the data collected, the definitions of data to be collected or in the application of the patient care algorithm system (PCAS). For example, the PROs are to refer PCAS issues to HCFA regardless of the source of the error, e.g., failure to refer (clinical data abstractor), unnecessary referral (physician reviewer), failure to identify a problem in a case referred for other reasons (physician reviewer). In addition, PROs have distributed responsibility for collating and analyzing these comments from the other pilot States and recommending appropriate refinements.

The AMA Practice Parameters Panel has agreed to coordinate comments on the clinical logic of the patient care algorithms, the appropriateness of the data collected and the definition of the data used in the UCDSS. The panel will, under the coordination of the AMA Office of Quality Assurance (AMAOQA), review the English Language Translation of the algorithms supplied by HCFA and will provide recommendations for changes to HCFA. HCFA will also furnish to AMAOQA all changes recommended by PROs or HCFA staff, and AMAOQA will transmit these to panel members for comment.

Specifically, the CDACs will be tasked with:

- Entering clinical data through the UCDS system.
- Running the electronic patient care screening system.
- Transferring the results and medical records to the PROs and the electronic records to HCFA.

Question No. 5. Dr. Gail Wilensky said at the budget briefing held by HHS that regionalization of both UCDS data abstraction and computerized review screening is being considered as a central strategy to increase program efficiency while reducing PRO expenditures. Please explain why regionalized UCDS data abstraction and computerized review screening is more efficient and less costly than PRO organizations performing these functions locally? Is not the review screening function a statutory responsibility of the local PRO because UCDS computerized review screening makes final affirmative determinations regarding medical necessity, appropriateness and quality of services as well as initial denial determinations? The PRO statute defines the PRO as the *only* entity legally responsible for making such determinations.

Answer. Clinical Data Abstraction Contractors (CDACs) represent a significant chance for the Federal Government to realize meaningful progress and cost-savings in the implementation of the Health Care Quality Improvement Initiative (HCQII). The limited number of abstraction-focused contracts (as opposed to 53 contracts focused on review of care) will allow the Health Care Financing Administration to carefully control the consistency, reliability, and timeliness of data abstraction. Accurate, reliable and timely data are crucial to the success of HCQII.

The ability of HCFA to closely manage the process is essential to provide many major benefits. These benefits include:

(1) The ability to respond quickly to operational needs and problems and make frequent refinements to contractor operations.

(2) The achievement of economies of scale leading to reduced expenditures in many cost centers, such as computer systems, supplies, rent, and communications.

(3) The opportunity to focus our limited resources on the assurance of the validity and reliability of the clinical data set nationally.

In the not-too-distant future, we expect hospitals to have adopted computerized patient record systems that capture this clinical data at the point of care. The data will be able to be transmitted directly into UCDS, avoiding the cost of abstraction.

The CDACs will *not* be making any professional review determinations. Rather, they will be conducting only clerical abstraction tasks and screening records for PRO review. HCFA will monitor the quality of the CDAC abstractions.

Responses of Secretary Sullivan to Questions Submitted by Senator Moynihan

Question No. 1. HCFA projected that Medicare payments to physicians would increase by an average of 16 percent nationwide for evaluation and management services. Are you aware that in Manhattan there will instead be a *reduction of 30 percent* for these services? Is this an intended, or is there a flaw in the new resource-based relative value system?

Answer. The resource-based fee schedule replaced Medicare's customary, prevailing, and reasonable charge system. The intent of the physician fee schedule was to correct historical payment imbalances and redistribute Medicare payments more equitably across types of services and geographic areas.

Therefore, although we were not specifically aware that Manhattan would receive a 30 percent reduction in these services, it is not surprising that an area with historically high physician rates would see reductions upon implementation of the fee schedule. This is not a flaw with the fee schedule or relative values, it is a perfect example of how the new Medicare physician fee schedule was intended to work.

Question No. 2. Are you aware that HCFA used New Jersey suburban residential data as a proxy for Manhattan commercial rents, and that these data vastly undervalue the cost of Manhattan rents in the Geographic Practice Cost Indices? Mr. Secretary, what can be done to correct this situation?

Answer. We are aware that Manhattan physician are concerned that their GPCI is too low, particularly because they believe that the high cost of rent is not adequately recognized in the practice expense GPCI. In developing the GPCI, data sources were required that were widely available and consistently calculated across all 232 fee schedule areas, and the only rental data meeting these criteria were the Department of Housing and Urban Development (HUD) data on residential rents.

The Bergen-Passaic (NJ) rent data were used as a proxy for Manhattan because Manhattan rent data were artificially low due to rent control. Therefore, the highest rent proxy in the New York City consolidated MSA, that for Bergen-Passaic, was

used. This worked to Manhattan's advantage as this was one of the highest rent proxies in the nation.

In any case, the rent component of the GPCI represents only about 11 percent of the total GPCI. Therefore, even a significant increase in this component would not result in a large increase in payments. For example, an increase in the rent component of 20 percent would increase payments in an area only about 2 percent.

The law requires that the GPCIs be reexamined at least every 3 years and updated if necessary. HCFA is in the process of collecting more recent data and searching for alternative data sources, including actual commercial rent data, in preparation of the first GPCI update.

RESPONSES OF SECRETARY SULLIVAN TO QUESTIONS SUBMITTED BY SENATOR ROTH

Question No. 1. Mr. Secretary, as you may recall, last year I introduced a bill S. 365 the Medicare Secondary Payer Reform Act to establish a central data bank where insurance information would be collected from W-2 forms. This central data bank would be queried when there is a question regarding primary insurance coverage for a Medicare beneficiary. According to previous Inspector General reports savings of up to $900 million annually could be achieved through improvements in the administration of the MSP program.

Could you please comment on the Department's views on MSP claims administration, especially in light of the budget proposals included to encourage more electronic claims administration and other carrier related provisions for Medicare contracted insurance carriers.

Answer. First, I would like to state that the IRS/SSA/HCFA data match project, enacted by the Omnibus Budget Reconciliation Act of 1989, is well underway. We expect to achieve significant annual Medicare secondary payer savings under this project, which will substantially reduce the total amount of outstanding secondary payer cases where Medicare paid inappropriately as the primary payer.

In addition to the data match project, however, the President submitted a bill to Congress on June 16 entitled the "Medical and Health Insurance Information Reform Act of 1992." Several of the provisions in this bill will have a substantial impact on simplifying and improving the process for coordinating benefits for all payers and result in a *substantial* increase in the Medicare secondary payer savings.

The "Medical and Health Insurance Information Reform Act of 1992" would enact certain measures related to electronic processing of claims, automated medical records, and comparative value information. Two of the provisions in this bill directly address the problem of coordination of benefits and transfer of information between payers. These provisions would:

(1) require the Secretary to promulgates rules, by January 1, 1994, for determining the priority of payment when two health policies cover the same person. We would envision that the Secretary would adopt the National Association of Insurance Commissioners protocol with few revisions.

(2) require the Secretary to determine, by January 1, 1995, whether problems related to the availability of information to perform coordination of benefits among insurers cause significant mistaken payments or administrative costs. If so, the Secretary would be required to promulgate requirements concerning the transfer of information among health insurers. These requirements could include the use of unique identifiers and the listing and sharing by insurers of all individuals covered under an insurance plan.

We believe that these provisions, in combination with the electronic claims processing provisions in the bill, will allow both the private insurance industry and Federal health programs to achieve a high level of information sharing and a significant improvement in proper coordination of benefits. We expect that many of the problems that exist today due to lack of information would disappear.

Question No. 2. Mr. Secretary, in the Administration's budget there are a variety of proposals to keep government spending under control, such as the increase in use of managed care plans. Could you please explain further how cost containment will be achieved in non-government health care spending. I am particularly interested in your insight on the managed care incentives.

Answer. I would first note that all the major cost-effectiveness reform initiatives identified in our reform proposal, from malpractice reform to reducing administrative and paperwork costs, are expected to contain costs in the private and government sectors alike. Managed care incentives are central to our strategy for reducing costs. We are convinced that the key to achieving cost stability without resorting to heavy-handed government price controls lies in the enhancement of market forces, in particular, through competition among various types of managed care

health plans such as PPOs and HMOs. The evidence is clear that these organizations can deliver health care more efficiently than fee-for-service medicine.

We would encourage development of managed care options in the private sector first by eliminating a host of anti-managed care laws—state laws that have the (usually intentional) effect of obstructing development of managed care. Private sector managed care growth will be stimulated by demand created by proposed income-related tax credits; credit recipients seeking out economical health plans would gravitate naturally to managed care plans.

PREPARED STATEMENT OF DICK ZARTLER

Mr. Chairman and members of the Committee, I am Dick Zartler, President, Grace Drilling Company, which has one of the largest fleets of land drilling rigs in the united States and operates in 18 States. Because of the breadth of our operations, we see first hand what is happening to drilling companies throughout the U.S.

The scene is not pleasant. February 10th's New Yorker magazine captures the essence of the collapse of the domestic oil and gas exploration and development industry in a "Talk of the Town" item titled:

VANISHED

> "A lot of people seem to come from Port Arthur, Texas—Robert Rauschenberg, Janis Joplin, Johnny Winter, Tex Ritter, just to name some of the best known. Traffic in the other direction must have been mighty sparse . . . .
>
> . . . . In the middle of a sunny Friday afternoon, and the city was totally deserted . . . . for block after silent, crumbling block, we saw no man, beast or going concern . . . .
>
> . . . . To call downtown Port Arthur depressed would be like calling the surface of the sun warm.
>
> What happened? The crash of the oil business . . . .
>
> Mr. Clark (our artist host) offered to show us Sabine Pass, a small town south of Port Arthur.
>
> At Sabine Pass, we found a regiment of offshore oilrigs, standing mothballed in the shallows of the Sabine River. looking up at the silent, rusting rigs from the riverbank, we felt as if we had wandered into a graveyard for sci-fi monsters. The rigs were gargantuan. They also are fantastically expensive . . . and when there was no immediate prospect of them operating profitably, their owners often had them cut up for scrap . . . 'which is what a lot of them are doing right now' . . . " (The New Yorker, February 10, 1992, pgs 26–27)

Port Arthur, Sabine Pass—these are some of the coastal communities that have collapsed.

Brookhaven, Mississippi; Kenai, Alaska; Elk City, Oklahoma; Williston, North Dakota; Casper, Wyoming; Sidney, Montana and Kilgore, Texas are but a few of the small inland communities that have met the same fate—"Vanished"—over the last six years as oil and gas exploration and development has collapsed.

The statistics are dry, but stark:

- 192,000 jobs lost in the extraction portion of the oil and gas industry from the 583,000 level in 1985 to 391,000 in 1991, a 33% decline.

  That is, on the average, 32,000 jobs per year, 2,667 jobs per month, 615 jobs per week or 88 jobs per day.
- 380 drilling companies have gone out-of-business, from 778 in 1985 to 398 in 1991, a 49% decline.

  That averages more than 5 companies per month going out-of-business for the last six years.
- 1,120 active drilling rigs loss, from 1,980 in 1985 to 860 in 1991, a 57% decline.

  That is equivalent to 15.6 active rigs each month over the last six years being shut-down.

  These relentless declines continue. At the end of January, 1992 the active rig count was at 653, the lowest level since records were kept starting in 1942.
- * Discoveries of oil and gas reserves are only at the 50% level of production.

(Please see the attached set of charts, prepared by Jesse L. Koontz, Vice President Grace Energy, tilted "The U.S. Drilling Collapse")

While these numbers seem cold, what is compelling is the human and national impact.

For instance, over the last 12 months, our company (which is typical of most of our 300 or so competitors) was forced to reduce our work force by 374 positions (about one of every six employees). More important, since most of our people live in small towns such as those mentioned above, they are typically the sole breadwinner. So when I say we laid off 374 people, unfortunately 374 families were devastated.

The industry's contraction is equally wrenching:

- High technology and modern drill rigs are being regularly packed up and shipped overseas for foreign ventures.
- Some rigs remaining at home are relocated to the active fields, but the vast majority are simply being cannibalized or scrapped.
- The technical superiority the United States has held in our industry for over 100 years is being seriously eroded by this economic devastation.
- The 192,000 or so in the skilled workforce who have lost their jobs are scattered to the winds and the message for the coming crop of students and graduates is to seek knowledge and disciplines in other fields. Petroleum engineering and geology degrees are no longer coveted by our young men and women.
- Research and development efforts are canceled because the financial rewards just are not present.

Our future capacity in education, research and capitalization of the drilling industry, is being undermined.

In short, what we are seeing is the hollowing out of the domestic oil and gas exploration and production capabilities of the nation.

This contrasts starkly with the national intent to expand the use of natural gas for alternatively fueled vehicles and other Clean Air applications.

The continuing collapse of the industry guarantees:

increasing dependence on foreign sources and
worsening balance of payments, with a foreign trade deficit derived entirely from oil and gas imports.

Working within the framework of flat prices for fossil fuels, there are measures that Congress can take to forestall the complete collapse of the entire domestic drilling industry.

We believe the inclusion of intangible drilling costs and percentage depletion as preference items in calculating alternative minimum taxes (AMT) unfairly penalizes the independent oil and gas producer and effectively prohibits the deduction of what had been, prior to 1986, legitimate business expenses.

Moreover, if the President's or any other economic growth package is passed without this, it not only singles the independent oil and gas operators out for continued inequitable treatment but also increases the inequity relative to other capital-intensive sectors of the economy.

As a result of these AMT penalties, which you are aware do not affect the major oil companies, the independents, who typically account for over 80% of the exploratory wells drilled in the United States, have significantly reduced their activity.

Since 1986 when the AMT penalties were imposed, exploration drilling has dropped 38% and development drilling has dropped 15%. This has measurably accelerated the decline in the domestic oil and gas exploration and development industry over the last ten years, as I have reviewed above.

In summary and simply put:

- The independent drilling operators are being penalized by the 1986 tax amendments.
- The U.S. is decapitalizing a strategic sector of its industrial economic base.
- The U.S. is putting at further risk its ability to respond to requirements for domestic oil and gas production.
- Jobs are being lost.
- Historical technological advantages are being eroded.

All we ask for is fair and equitable treatment. We are not asking for favors—simply equal treatment. We urge you to eliminate these onerous AMT preference items of the 1986 tax act. This will put our people to work again.

Thank you.

Attachments.

THE U. S. DRILLING COLLAPSE

A CRISIS IN THE U. S. OIL & GAS INDUSTRY

Jesse L. Koontz
Vice President, Economic Analysis

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February 1992

A CRISIS IN THE U. S. OIL AND GAS INDUSTRY

- Drilling activity in the U. S. is collapsing--the drilling rig count by the end of January was the lowest in more than 50 years and is expected to drop even lower.

- Independent oil and gas operators are fast disappearing--so are U. S. drilling companies, U. S. oil field equipment manufacturers and other U. S. oil field services companies. Companies with decades of experience are continuing to close their doors.

- This means a massive loss of U. S. jobs--from 1985 to 1991, 192,000 workers, mainly roughnecks, machinists, welders, truck drivers and contractors, have been laid off with devastating impact on families since most workers live in rural areas and are the sole breadwinners.

- Thus, another strategic sector of the U. S. industrial base is being decapitalized. Technical superiority of the U. S. oil and gas industry is jeopardized. Environmental objectives may be thwarted in the near future if an exhausted industry is unable to provide necessary quantities of clean domestic fuels, particularly natural gas.

- Declining oil and gas prices have taken their toll on the industry but counterproductive and inequitable U. S. government policies are making foreign exploration more attractive. A major negative is the alternative minimum tax provision, which effectively prohibits the deduction of legitimate business expenses. This discourages oil and gas investment by subjecting risk capital to high marginal tax rates.

- Restoring equitable tax treatment to the industry would put people back to work immediately. A review of the industry's collapse and reasons for nationwide concern follow.

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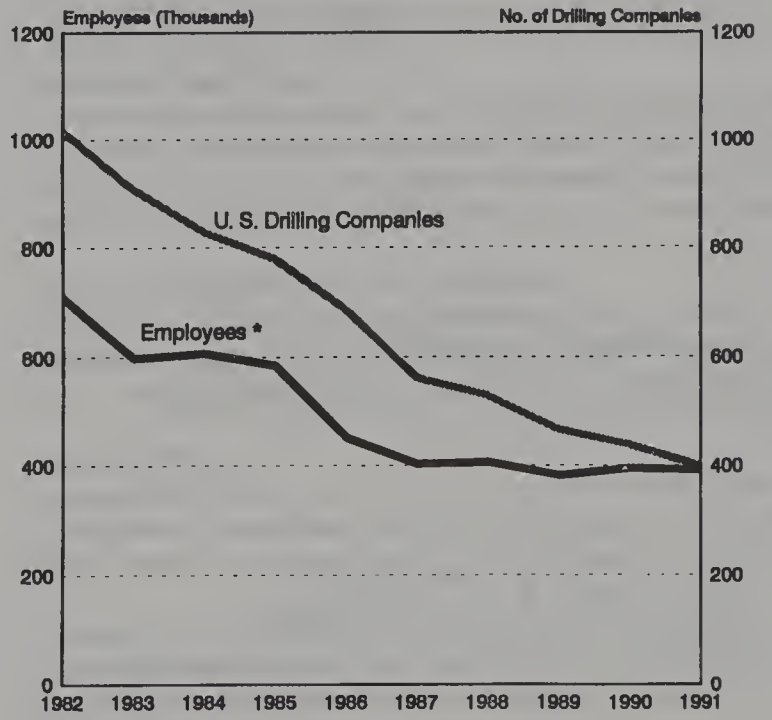
U . S. DRILLING COMPANIES AND RELATED JOBS ARE EVAPORATING . . .

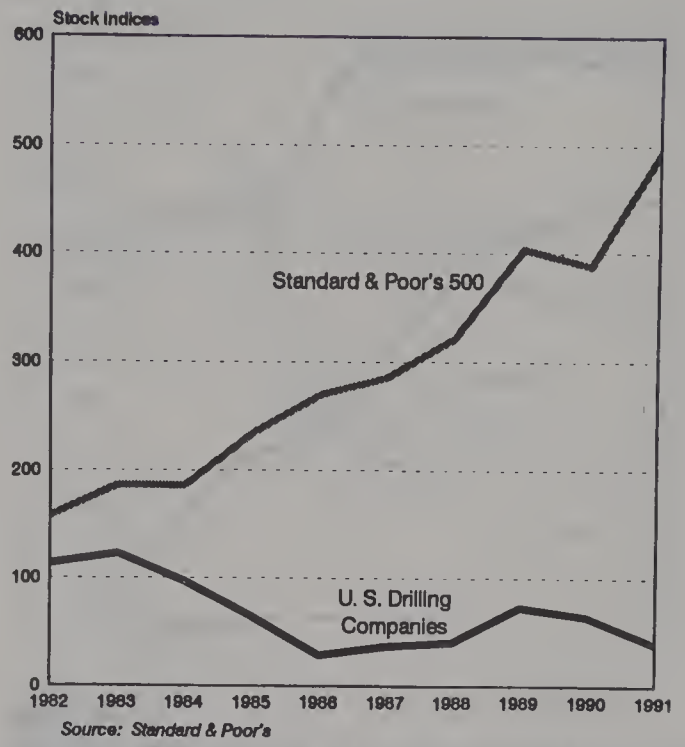


Source: BLS, IADC

** Note: People employed in U. S. oil and gas extraction businesses.*

- Between 1982 and 1991, the number of U. S. drilling companies dropped by 617, or 61%.
- Despite relatively stable oil and gas prices in recent years, companies have continued to fold, with several competent and experienced companies announcing their withdrawal from the U. S. in the past few weeks.
- The related job loss over the past decade is 317,000, or 45%, and layoffs have recently accelerated.

FINANCIAL MARKETS REFLECT THE DIRE ECONOMIC CIRCUMSTANCES IN THE U. S. OIL PATCH . . .



Source: Standard & Poor's

- The U. S. drilling industry has not participated in the overall stock market boom of the past decade.

- The Standard & Poor's 500 stock index more than tripled between 1982 and 1991, while the index for drilling companies dropped 66% over the same interval.

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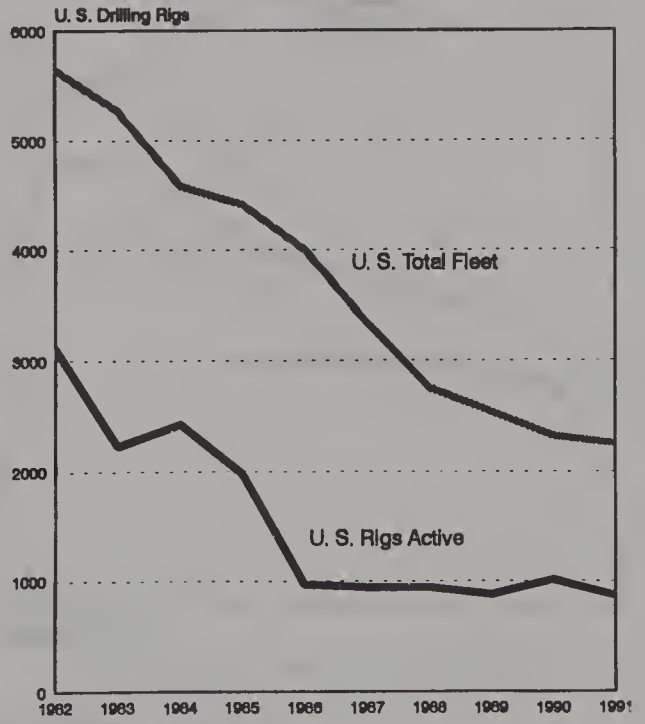
February 1992

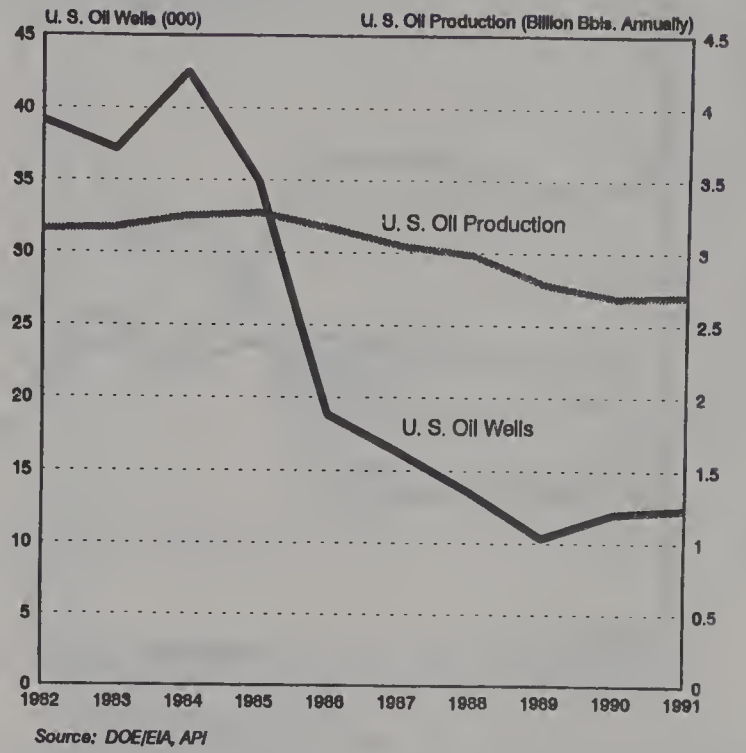
DECLINING U. S. DRILLING ACTIVITY IS RESULTING IN A POTENTIALLY DISASTROUS DROP IN THE CAPABILITY TO SATISFY FUTURE U. S. ENERGY NEEDS . . .



Source: Baker Hughes, Reed Tool Co.

- Rigs working in the U. S. fell by 2,245 rigs, or 72%, from 1982 to 1991.
- The active rig count in January this year fell further to 653, down 38% from the year earlier level, and is a 50-year record low (lower even than in 1942 when drilling was curtailed by wartime priorities).
- Rigs scrapped, cannibalized or exported between 1982 and 1991 totaled 3,393, or 60% of the 1982 fleet, and as many as half of the 2,251 counted in 1991 are no longer capable of working.

WITH THE CUTBACKS IN DRILLING, U. S. OIL PRODUCTION IS FALLING . . .



Source: DOE/EIA, API

- U. S. oil production has declined an average of 3.2% per year since the recent peak in 1985.
- After the temporary lift from high oil prices during the recent Iraqi conflict, U. S. oil production is again declining.
- Drilling currently is about half the level required to sustain U. S. oil output.

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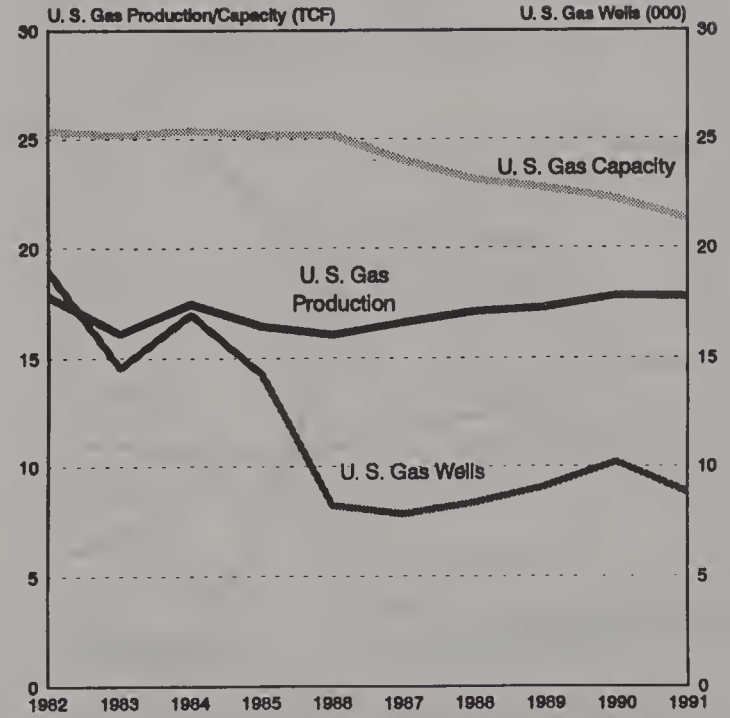
February 1992

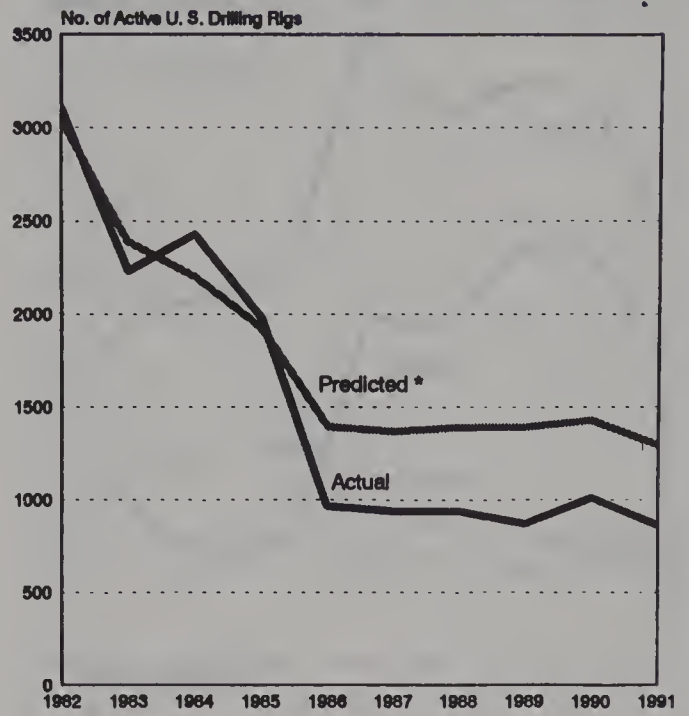
U. S. GAS PRODUCTION CAPACITY IS ALSO FALLING AT CURRENT DEPRESSED DRILLING LEVELS . . .



Source: DOE/EIA, API

- Current gas production capacity exceeds gas production; thus, gas prices are depressed.
- However, gas production capacity has been falling at 3.3% per year over the past five years as drilling has dropped below the 12,000-well-per-year level estimated by government studies as required to sustain capacity.
- At today's low drilling level, the gas production capacity surplus will soon be eliminated, whereupon a financially strapped gas industry may be unable to respond to growing demand for this environmentally favored fuel. A significant gas price increase would follow.

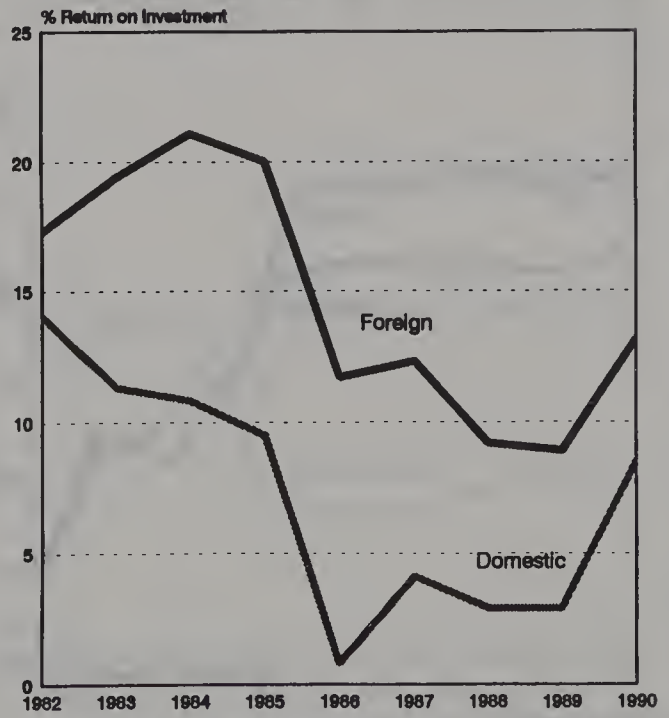
THE DECLINE IN OIL AND GAS PRICES FROM PEAK LEVELS IN THE EARLY 1980s CONTRIBUTED TO THE U. S. DRILLING DECLINE, BUT SINCE 1985 ADVERSE GOVERNMENT POLICIES HAVE TAKEN THEIR TOLL . . .



Source: Baker Hughes, GEC Analysis
** Note: On the basis of oil and gas prices.*

- Regression anaiysis shows marginal oil and gas prices (and time) account for 93% of the variance in active rig count over the iong term.
- A regression equation based on historical data through 1986 indicates factors other than oil and gas prices have been depressing activity since 1986.
- The adverse factors inciude inequitabie tax treatment imposed on the oil industry in 1986.

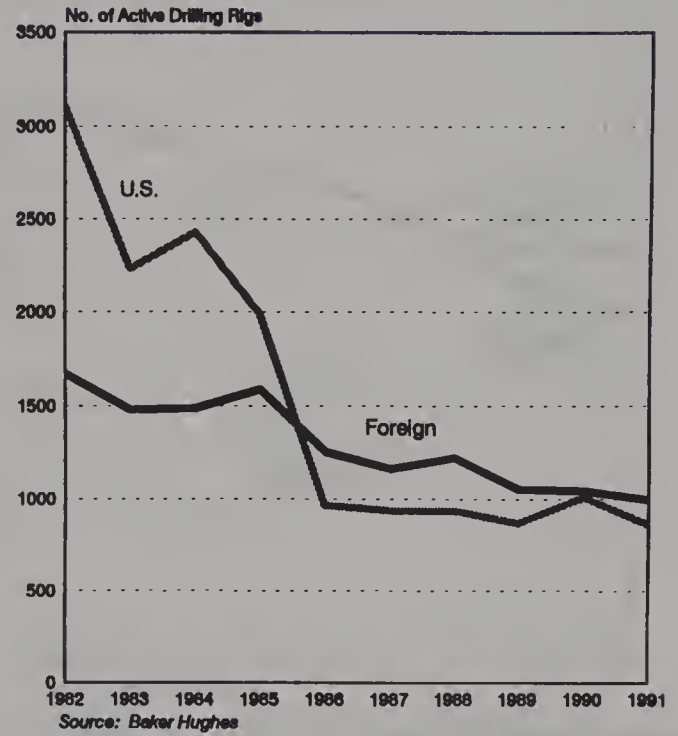
DECLINING OIL AND GAS PRICES HAVE CUT RETURNS ON INVESTMENT FOR THE OIL AND GAS PRODUCTION BUSINESS WORLDWIDE . . .



Source: DOE/EIA

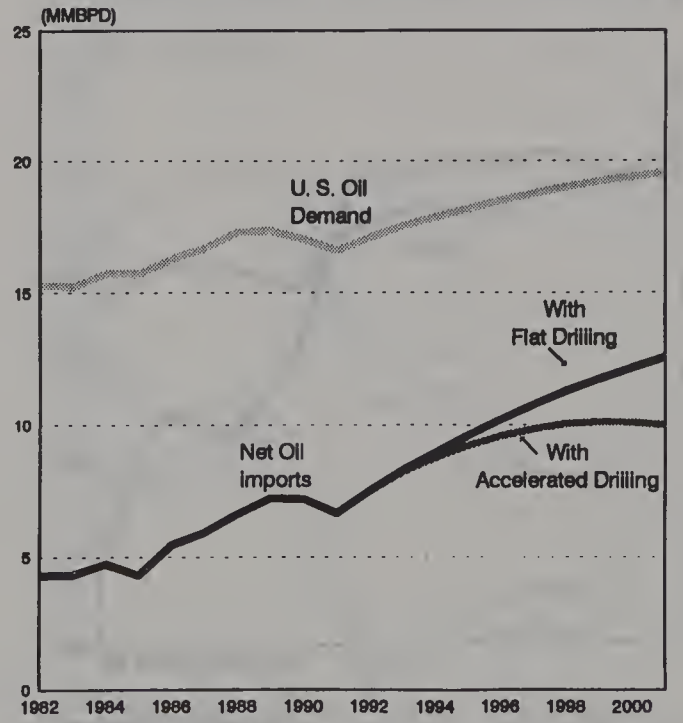
- However, despite comparatively favorable finding and development costs in the U. S., returns on investment elsewhere in the world have not declined as sharply and remain significantly higher than those in the U. S.
- The trends reflect recent efforts by most countries to attract oil and gas investment, whereas the U. S. has moved in the opposite direction.
- Except for a temporary lift from high oil prices during the Iraqi conflict, fourth quarter 1990, the return on investment for U. S. oil and gas production has been shockingly poor since 1982, in sharp contrast to the public image of a highly profitable industry.

COMPARATIVELY LOW RETURNS ON INVESTMENT FOR THE U. S. OIL AND GAS PRODUCTION SEGMENT ARE CHASING INVESTMENT CAPITAL ELSEWHERE . . .



- The U. S. active rig count, at one time nearly twice the level of that outside the U. S., has fallen to a level below the foreign rig count.
- From 1982 to 1991, the U. S. rig count has fallen 72%, whereas the foreign rig count declined only 40%.
- Investment in the U. S. is discouraged not only by inequitable tax treatment but by uncertainty associated with regulatory and environmental controversies.

DISINTEGRATION OF THE U. S. DRILLING AND OIL FIELD SERVICE INDUSTRY RISKS SHARPLY INCREASING OIL IMPORTS . . .



Source: DOE/EIA, GEC Analysis

- Growth in U. S. oil demand, stalled with the current recession, will probably continue at a moderate rate for years to come.
- With revived drilling activity, the slide in U. S. output can be halted, thus curtailing growth in oil imports.
- However, absent a redirection in government energy policy, a decimated U. S. oil field industry may require years to reassemble the talent and equipment needed.
- With drilling flat at current levels, net oil imports could double within 10 years and account for 64% of domestic oil demand.

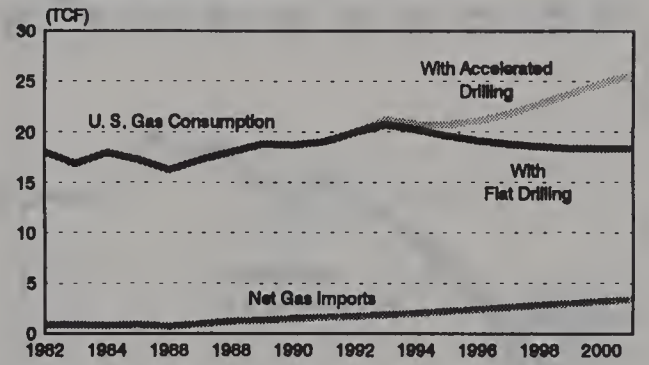
THE U. S. NET PETROLEUM TRADE DEFICIT WILL SOAR IF U. S. DRILLING DOES NOT REVIVE . . .

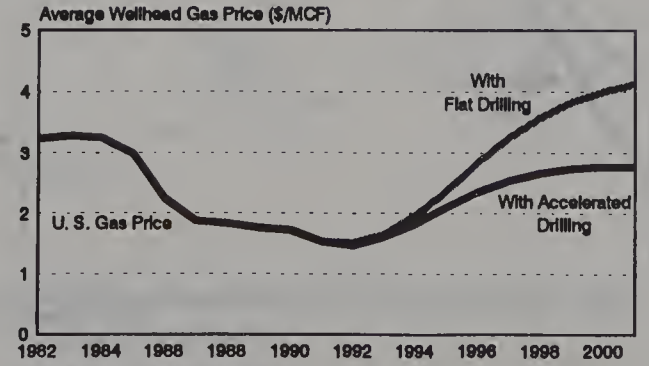
Source: DOE/EIA, GEC Analysis

**Note: Projection assumes oil prices increase with inflation only for the next five years and four percentage points faster than inflation for the following five years.*

- With no increase in drilling from the current level, the bill for net U. S. oil imports nearly quadruples over the next decade, thus guaranteeing a continuing trade deficit problem.
- increased oil imports promise slower economic growth and an increased environmental price tag, while restricting foreign policy options and aggravating national security risks.
- The graph at the left may be over-optimistic as it assumes oil prices are flat in real terms for many years. However, the world oil balance is precarious--accidents to major oil supply facilities, violence in the Middle East, further disruptions to Russian production, etc., could send oil prices and the trade deficit soaring.

A MORIBUND DRILLING INDUSTRY ALSO PROMISES MAJOR DISAPPOINTMENTS FOR THOSE COUNTING ON INCREASED USE OF CLEAN-BURNING NATURAL GAS . . .





Source: DOE/EIA, GEC Analysis

- The U. S. is blessed with abundant gas resources (over 60 years' supply at current usage). However, these resources are available to consumers only if enough wells are drilled.
- Absent increased drilling, the current gas surplus will disappear within the next 2-3 years, thus capping gas use (even with sharply increased gas imports).
- Flat drilling also results in much higher gas prices as substitute fuels (mainly oil) are burned to compensate for limited gas supply.
- Alternatively, with constructive policy changes to restore the oil and gas industry to reasonable financial health, supplies of natural gas should be plentiful and available at bargain prices.

COMMUNICATIONS

STATEMENT OF THE AMERICAN ASSOCIATION OF BIOANALYSTS

The American Association of Bioanalysts (AAB) is pleased to present its views to the Senate Finance Committee regarding the Administration's Fiscal Year 1993 Budget. AAB is comprised of owners, directors, managers, and supervisors of independent community-based clinical laboratories from across the country.

As you are aware, laboratories are reimbursed under a fee schedule for Medicare services. Since 1986, the amounts payable under the fee schedule have been limited by a national cap. This cap is currently set at 88 percent of the median of all carrier rates. The President's Budget includes a proposal to reduce the cap to 76 percent of the median. In addition, the Administration has proposed an unspecified reduction in the CPI adjustment to the fee schedule.

AAB is firmly opposed to these proposals. Further reductions in the fee schedule are unreasonable in light of the substantial cuts which have already been imposed on the industry. During the last eight years, the fee schedule has been reduced nine times and frozen twice. The net result is that for many tests, the FY 1992 reimbursement level is only half of the 1984 rate. In contrast to reductions applied to most other providers, these are real cuts, not just cuts in inflation adjustments.

The national cap on the fee schedule was originally instituted to equalize payments between carriers. However, that objective has been achieved by previous reductions. Few, if any, carriers have schedules which are less than the current cap.

The reduction in the national cap proposed by the Administration would have a devastating effect on most independent community-based clinical laboratories. These labs are already losing money on Medicare testing. Many provide unique services in settings not served by the large commercial laboratories.

Under the Administration's proposal, the laboratory industry would be forced to shoulder a disproportionate share of the FY 1993 Medicare reductions. Laboratory payments constitute less than 5 percent of all Medicare Part B expenditures. Yet, 72 percent of the Administration's Part B cuts come from this program.

The reductions proposed by the Administration will also take effect at the same time the industry is required to implement several new federal regulations. These regulations include the Clinical Laboratory Improvement Act (CLIA '88) and OSHA's Blood Borne Pathogen Standard. Each of these rules will increase the cost of laboratory testing. For example, OMB estimates the cost of the final CLIA rule will exceed $1 billion in FY 1993.

If Congress is serious about controlling Medicare laboratory expenditures, attention must be focused on controlling utilization. Simply ratcheting down the fee schedule has not, and will not, produce savings. Independent labs do not order tests, physicians do. As long as the doctors can profit by ordering tests, costs will rise.

The Stark Bill, which took effect in January, is a partial solution to this problem. Physicians are now prohibited from maintaining ownership interests in independent laboratories. However, the Stark law does not address the primary setting in which physicians profit from laboratory testing—the doctor's office. Physician office testing now accounts for more than 50 percent of all Part B laboratory expenditures. Ironically, until the passage of the 1988 amendments to CLIA, these laboratories were also exempt from federal quality control guidelines. We hope that the implementation of CLIA will not only improve physician office testing, but will also help control excessive utilization in this sector.

We also support legislation mandating direct billing for all laboratory services. In many cases, doctors negotiate discounts on the tests they send to outside labs for their non-Medicare patients. The laboratory charges are then marked up by the physicians before they are forwarded to the patient or third party payors. This practice results in testing patterns which drive up Medicare as well as private pay costs.

This trend should be stopped by extending the current Medicare direct billing requirement to private pay patients.

Finally, we would like to provide the Committee with our views on a report prepared by the General Accounting Office (GAO/HRD–91–59) which suggested that additional reductions in laboratory payments might be appropriate. This GAO study is seriously flawed and should not be relied upon for the purpose of setting laboratory reimbursement rates. Some of the most significant defects in this study are outlined below:

- *Analysis of only a small segment of the industry.* The GAO did not sample any physician office or hospital laboratories. Yet the Inspector General's Office has reported that these sectors account for nearly two-thirds of all Part B laboratory expenditures. These two sectors are generally believed to have higher costs than the large independent laboratories.
- *Size of Sample.* The GAO study examined only very limited number of laboratories. According to the GAO there are over 110,000 laboratories in the United States. However, this report is based on a review of only 16 independent laboratories. Data was collected from 5 large and 11 "small" independent laboratories.
- *Services Provided by Large Laboratories.* In many cases, the populations served by the large independent laboratories differ significantly from those served by smaller laboratories. The small community-based independent laboratories often serve nursing homes and other higher cost customers ignored by the large laboratories. Consequently, it would be inappropriate and unreasonable to assume that the cost structure of the large laboratories should be applied to the entire industry.
- *Small Laboratory Sample Selection.* The "small" laboratories selected by the GAO do not accurately reflect the industry. GAO examined the records of 11 small labs. Five of these labs were suggested by AAB. The GAO has indicated that the remaining six were selected to provide diversity in the location and size of laboratory studied. AAB is appreciative of the GAO's desire to expand the sample. This is something were strongly encourage. However, the additional laboratories selected by the GAO are particularly unrepresentative of the small laboratory industry:

  —Two of the six laboratories are from Nevada. Nevada is the only state in the Union which does not permit physicians to bill for laboratory services under Medicaid. These two labs handle most of the testing in the State and account for over 54 percent of the volume of all the smaller labs included in the GAO study.

  —The GAO selections did not produce geographic diversity. The final sample of eleven labs included 3 from California, 3 from Illinois, 2 from Nevada, 1 from Ohio, New Jersey, and Missouri.

  —Three of the six laboratories selected by GAO had annual revenues of over $13 million. These labs are not representative of the small laboratory sector. They are more like the large laboratories and should not have been included in this portion of the study.

- *Treatment of Owner/Director Salaries.* The GAO treated owner/director salaries in small laboratories as profit. This is an unreasonable assumption. If the owner was not serving as director, the laboratory would have to hire someone to work in that capacity.
- *Accuracy of the Data Reported.* At least two of the AAB laboratories participating in this study have provided us with the reports they were provided by the GAO on the profitability of the various lines of work conducted in their laboratories. In each case, the GAO confirmed, via a written statement, that these laboratories were losing money on their Medicare work. Yet, this data does not appear in the final GAO report which brings into question the GAO's overall conclusions regarding the profitability of Medicare testing in small laboratories.
- *Additional Costs on the Industry.* The GAO report was completed prior to the implementation of the new CLIA '88 regulations and the Blood Borne Pathogens Standard. As previously mentioned, these two rule will impose very significant new costs on the laboratory industry.

For these reasons, we would urge you to reject the Administration's proposals for further reductions in the clinical laboratory fee schedule. At the same time, we stand ready to work with the Committee in developing alternative measures to reduce Part B laboratory costs by controlling overutilization. Initiatives which focus on limiting excessive physician testing are the only measures which will produce real program savings.

Statement of the American Medical Association

The American Medical Association (AMA) appreciates this opportunity to share its concerns on the following health care access issues raised by the Administration's Fiscal Year 1993 budget submission and its expected impact on the Medicare and Medicaid programs which provide a safety net of medical care for a significant number of Americans.

The AMA is concerned that the Administration's FY 1993 budget proposes a strict cap on Medicare and Medicaid expenditures. The current 1993 budget also proposes to cut Medicare benefits by $14 billion over the next five years, with no commensurate benefits in Medicare provided in exchange for these cuts. These continued reductions reflected in the Administration's Medicare proposals continue an unfortunate trend of effecting arbitrary cuts in human service program funding that can only lead to reduced access to needed medical services.

ENTITLEMENT CAP

The AMA vigorously opposes the proposal to cap Medicare and Medicaid program increases (as well as other entitlement programs) at a growth rate of population + CPI + an average of 2.5% prior to the implementation of comprehensive health reform. After implementation of comprehensive health reform, this cap on the rate of entitlement growth would slow to population + CPI + an average of 1.6%.

The imposition of arbitrary caps undercuts the very foundation of human needs and the purpose of entitlement programs—that funds will be available to meet the needs. Under the proposed formula, the Medicare and Medicaid programs will be unable to maintain even the current levels of services in the not too distant future. With state funding for Medicaid already far below actual beneficiary needs, this proposal quickly would result in diminished access to needed health and medical care for those most in need. If the Administration wants to reduce entitlement spending, it should adopt a rational approach, such as review of each program to determine if it should remain in its current format, rather than enact an arbitrary and potentially harmful cap.

On top of the proposed Medicare and Medicaid program cap, the Administration calls for a significant restructuring of Medicaid through its proposed requirement that states place all Medicaid beneficiaries in managed care plans unless the state seeks and obtains a waiver of this requirement. This requirement may prove particularly impractical for states with isolated population centers. Furthermore, existing and successful means of receiving care may be needlessly eliminated. This new and arbitrary system should not be imposed on the states. We believe that the states should be allowed full flexibility and that they should not be required to seek HCFA waivers to cover Medicaid beneficiaries outside of a managed care system.

MEDICARE PROPOSALS

1. The AMA opposes the provision to set a single fee for anesthesia services, regardless of whether an anesthesiologist personally performs the service or medically directs a certified registered nurse anesthetist.

This proposal, with slightly more background information, was presented in the FY 92 budget. The FY 1992 budget added the element that, in situations where a certified registered nurse anesthetist (CRNA) is involved in the care, the Medicare payment for the anesthesiologist's direction would be the difference between the fee paid if the anesthesiologist personally performed the service and the amount paid to the CRNA. This provision is inconsistent with the background and training of the personnel involved in providing anesthesia care and with the practice of providing this care. By capping payment at the amount allowed for care provided by an anesthesiologist, the proposal would create incentives against the use of CRNA services. Significant problems would be likely to arise in situations where the CRNA is not employed by the anesthesiologist. While payment for the anesthesia care team should not necessarily be more than payment allowed for just the services of an anesthesiologist who provides the full range of anesthesia care, the payment at least should be consistent with and based on the resource costs of all of the services provided.

2. The AMA opposes the provision to reduce the existing cap on carrier payment schedules for clinical laboratory services from 88% to 76% of the median amount allowed by all carriers. The AMA supports the use of more accurate data in the update process to reflect current market factors.

While the AMA has supported modifications in the way updates are set so that those updates more accurately reflect changes in the cost of providing care, the Association has opposed arbitrary reductions in Medicare payment levels. This proposed cut, especially on top of pending new regulatory requirements and costs for office laboratories, could make it difficult for physicians to continue providing these services to Medicare beneficiaries and could reduce access to needed laboratory services.

3. The AMA opposes the provision to move the hospital payment update from October 1 to January 1.

This type of smoke and mirror proposal is no more than an arbitrary delay to achieve budget savings with no programmatic rationale.

4. The AMA supports increasing the II premium rate for individuals with annual income of more than $100,000 and for couples with annual income of more than $125,000.

When many Americans with incomes below the poverty line go without health benefit coverage, individuals and couples with income levels above $100,000 and $125,000 should not be recipients of subsidies. The Association consistently has supported reasonable "means testing" of the Medicare and other government programs.

5. The AMA supports the proposal for state and local government employees hired before April 1, 1986 being included under Medicare.

The AMA continues to support universal Medicare coverage for all people eligible by reason of age and disability.

6. The AMA supports increasing the Medicare contractor budget for carriers and intermediaries by $187 million to $1.64 billion, but also strongly recommends the inclusion of a contingency fund.

The AMA has questioned the adequacy of the current contractor budget, and particular problems concerning the release of contingency funds arose both in 1990 and 1991. Adequate contractor funding is essential to assure prompt claim processing and services for beneficiaries and physicians. We also support the creation of an expanded contingency fund for use if the budgeted amount is not adequate to assure prompt claims processing and responses to beneficiary and physician/provider inquiries.

7. The AMA supports adequate Peer Review Organization (PRO) funding.

The AMA continues to maintain that the PRO program needs adequate funding to operate effectively, especially in light of growing PRO responsibilities.

MEDICAID PROPOSALS

The AMA has consistently supported adequate funding for the Medicaid program and strongly opposes any budget cuts targeted at health care programs currently provided for our most vulnerable people.

The Administration proposes three changes that are projected as saving roughly $104 million in FY 1993 in the Medicaid program. Specifically, it proposes: (1) requiring states to ensure that noncustodial parents maintain health insurance coverage for their children; (2) encouraging AFDC recipients to undertake entrepreneurial activities to achieve self-support through self-employment; and (3) establishing fees for certification of facilities to participate in the Medicaid program.

1. The AMA supports requiring noncustodial parents to maintain health insurance for their children if they have access to affordable coverage.

The AMA believes that incentives to encourage parents with access to health benefit coverage to accept their family responsibilities will help to empower individuals and may work to strengthen needed family links. Acceptance of parental responsibility, even in this small regard, will help in reducing the significant health problems that children may face.

2. The AMA has no position on the entrepreneurial activities of AFDC recipients.

3. The AMA opposes fees for certification of facilities.

The imposition of fees to certify health care facilities that provide care for Medicaid beneficiaries is a misplaced attempt to generate additional funds at the expense of the caregivers who can least afford such fees. An imposition of an arbitrary fee could reduce health care access as physicians and others struggling to provide serv-

ices under an already underpaid system are faced with yet another financial burden in providing these services.

This proposal lacks a rational nexus to improvement of health services to Medicaid beneficiaries. Federal "certification" fees are unwarranted, as state law already protects Medicaid patients through licensure requirements and other legal safeguards to assure quality of care. The AMA urges the Committee to adopt its position to oppose the imposition of such an arbitrary and burdensome fee.

CONCLUSION

While the Association is pleased that this year's series of budget proposals provides a respite from past proposals that set forth wide ranging and detrimental program cuts, we still are concerned with the use of the budget process to make major and arbitrary program changes that could undermine access to needed care. Examples of such past program changes that need to be addressed include the removal of payment for physician interpretation of EKGs and lowered payment for "new" physicians. In fact, this Committee should support the repeal of these two provisions as it considers Medicare program changes this year. If any additional program cuts are imposed, the resulting savings should be used for beneficiary benefits such as the restoration of full payment for new physicians and coverage for EKGs.

Statement of the Coalition for Competitive Capital

My name is Kenneth L. Lay. I am chairman and chief executive officer of Enron Corp. in Houston, Texas. I appear before you today as chairman of the Coalition for Competitive Capital (CCC), a group of major corporations dedicated to restoration of a permanent and effective 10-percent investment tax credit (ITC). The list of members of our rapidly-growing coalition is attached as Appendix A.

THE PROPOSAL

CCC recommends that Congress reinstate at the earliest opportunity a 10-percent ITC, targeted to that portion of producers' durable equipment integral to producing and transporting goods and energy, as well as to pollution control and other investment mandated for environmental purposes. Eligible assets would include equipment used in agriculture, agri-business, and manufacturing, as well as equipment that forms an important part of the nation's infrastructure, such as passenger and freight-carrying aircraft and railroad equipment operated by common carriers. The targeted ITC would not apply to furniture and fixtures, office equipment, executive jets, and the like. One of my favorite examples to make the essential case for targeting relates to a steel company investment in equipment: a new continuous casting process would be covered; purchase of a new desk for the CEO would not. This contrasts, of course, with earlier versions of the ITC, which covered all business assets except buildings. A partial list of the types of equipment that would and would not be eligible for the targeted ITC is attached as Appendix B.

However, critical to this proposal are two central points. First, there is no case either in terms of economics or equity to pay for a new ITC by raising other taxes on business -- that would hardly help the recovery we need and simply be a case of robbing Peter to pay Paul. Indeed, from an economic standpoint, a very strong case can be made against raising any taxes during this period of recession.

Second, to be effective, any new ITC must be creditable against the corporate alternative minimum tax. That tax, now hitting more than half of the nation's corporations, is strongly anti-investment and anti-growth, and I am very happy to see that the President has asked for some relief from it. In the current instance, failure to apply any ITC benefits to reductions in AMT liability would sharply reduce the positive impact of the ITC.

Mr. Chairman, I shall return later in my statement to the case for targeting the credit, the importance of making it full rather than incremental and other issues specific to the proposal. First, however, I want to address the more fundamental questions of enhancing business investment, its role in economic growth and international competiveness, and the importance of tax policy in influencing such investment.

BUSINESS EQUIPMENT AND ECONOMIC GROWTH

Mr. Chairman, the long battle between the advocates of a market approach to solving mankind's economic problems versus state control and planning is over; markets and democracy are the clear winners. Central to this success has been the unmatched efficiency of the market system in facilitating the saving and investment that are the key to growth in jobs, output and living standards.

Yet not all market economies move at the same pace in providing good jobs and higher living standards. There are a large number of reasons for this disparity, but I suggest that Table 1 tells an important part of the story -- a story which, from the standpoint of the United States, is less than encouraging. Table 1 shows saving and investment rates in the major industrial democracies from 1973 through 1989. The U.S. ranks last on that list in every major category of saving and investment but two, where we are either next-to-last or tied with the United Kingdom. For example, our net rate of national saving was half that of Western Germany's and one-fourth the rate in Japan. Most important, in gross non-residential fixed capital formation -- the economist's long-winded way of saying business investment in plant and equipment -- the U.S. is at the tail end of the list. Moreover, if figures for the past decade alone were examined, we'd find that the U.S. had fallen back even more.

To highlight my point, Mr. Chairman, let me point out two things that will shock many Americans. First, total plant and equipment spending in Japan now exceeds that of the United States, even though Japan's GDP is no more than 60 percent of ours. Second, Japan has been investing twice as much per worker as the U.S. That's what we economists refer to as the depth of capital formation; in lay terms, it means that the tools Japanese workers have at their disposal are growing much faster than in this country. And, needless to say, those new tools are of the highest quality and most modern design.

Again, Mr. Chairman, it would be an overstatement to say that the negligible growth in U.S. real per capita income since 1973 has been caused solely by our sluggish investment performance. But it is a big part of the story, just as it in part explains the lack of resiliency of the U.S. economy in its struggle to emerge from recession.

THE CRUCIAL ROLE OF INVESTMENT IN EQUIPMENT

Defined very broadly, capital formation includes a wide variety of capital goods, that is, all assets which are consumed over a period of time rather than currently. Residential construction is a big part of U.S. capital formation, as is growth in commercial property. Inventories are capital, albeit of relatively short life. Business fixed investment -- plant and equipment -- is much more important to long-term growth in jobs and living standards than other types of capital formation. And within that total, producers' durable equipment is especially important.

This fact has been recognized for a long time. On the governmental front, it spurred some depreciation liberalization and reform in the Eisenhower years. But full recognition of the crucial role of equipment to economic growth did not emerge until John Kennedy became President. Two of his earliest actions prove this point. He directed the Treasury Department to modernize and liberalize the depreciation guidelines in two major industries and -- of overriding importance -- he asked Congress in early 1961 to enact a seven-percent ITC. President Kennedy viewed these actions as part of his campaign theme, "To get the country moving again," and to enhance U.S. competitiveness in international markets (yes, international competitiveness was a major concern of U.S. policymakers even as long as three decades ago).

Congress responded, albeit slowly and reluctantly, and approved the ITC in October 1962. Good things began to happen in the U.S. economy. Over the next several years, jobs rose rapidly, inflation was held in check, and productivity grew at a record peacetime rate. To be sure, the ITC was only part of a whole complex of extremely well thought-out economic policies, but it was a very important part. (Those years of outstanding economic performance came to an end after 1965, however, as federal spending on both Vietnam and domestic programs rose sharply.)

All of us know the history of the ITC since those early days. The credit was turned off in 1966 but hastily restored in 1967; off-again, on-again in 1969-71; elevated to 10 percent in 1975 and "made permanent" in 1978. The ITC served as the linch pin of a highly effective and competitive capital cost recovery system enacted in 1981. It was finally repealed as a "tax loophole" in 1986.

Mr. Chairman, I dwell on these three decades of experience for two reasons. First, it shows that the ITC has not been a partisan issue; it is not, for example, surrounded by the controversy that complicates our approach to taxing capital gains. Second, the record shows that each time an ITC was turned on or improved, good things happened to the economy. Each time it was turned off, bad things happened.

SUMMERS AND DE LONG

Both common sense and the historical record tell us that the ITC should be a permanent part of our tax code. Now we have some solid economic research to support that view. In a research paper published by the National Bureau of Economic Research last year (see Appendix C for a summary), Professors Lawrence Summers and Bradford De Long of Harvard (you will recall that Professor Summers was chief economic adviser to Governor Dukakis in the 1988 presidential campaign) examined country-by-country patterns of economic growth. They concluded that investment in equipment is the single most important factor in a nation's economic growth and development. That is a very important conclusion in itself, and elevates equipment investment to a much more important role in economic growth than earlier scholars had thought to be the case. Even more startling is the finding that, for each one percent of GDP invested in

equipment, the growth rate of that country's GDP will increase by one-third of one percent. That, Mr. Chairman, is a very high rate of return.

This does not mean that other factors are not important in the growth process. Human caital in the form of education and training -- unqualified workers cannot handle sophisticated tools -- is obviously crucial. Research and development is essential, as is efficient technology transfer. But the end-all and be-all of this effort in a modern market economy is a successful melding of all these forces to create more and better tools for the workers -- that is, modern, state-of-the-art machinery and equipment. In other words, human capital, technology, and the equipment itself -- all are essential to strong investment performance.

THE RECENT RECORD

An "eyeball examination" of the second line in Table 2 indicates that this country has not been doing all that badly in fostering growth in business equipment. That table shows that the growth rate in the stock of business equipment averaged between four-and-one-half and five percent in the years 1950-1979, and fell off to only 4.1 percent in the 1980's. But the overall figures are highly misleading; the disaggregated data tell an entirely different story. When information processing equipment is backed out of the total, the rate for the decade of the 'eighties drops dramatically, to only about one-third of the earlier periods.

What happened? Business went on a computer-spending spree in that decade. And that did not stop with repeal of the ITC in 1986 -- the price of computers dropped (relatively) so much that the repeal of the ITC, which would otherwise have increased the capital cost of such investment, was not noticeable. Not shown on the chart are the growth records of industrial equipment and airplanes, which also fell off sharply.

Is this to say that installation of ever-more efficient computers for accounting and other office purposes, "back-room" functions at securities firms, and a variety of financial-service functions is "unproductive?" Certainly not. But it can hardly be denied that, for the typical industrial firm, a new office computer adds much less to output per hour per person than an increase in equipment used directly in the process of production. And as for services, this promising area of economic growth must be viewed differently from industrial output when factors affecting international competitiveness are considered.

Stated simply, regardless of how competitive we become in the services sector, and even assuming that we are able to open some closed foreign markets sufficiently to compete in services on a level playing field, the key to long-run equilibrium in the balance of U.S. international accounts must rest primarily on industrial competitiveness. Perhaps the best explanation of "why manufacturing matters" must be strengthened is contained in Made in America, the excellent 1989 report of the M.I.T. Commission on Productivity. That commission said:

> ...some see a transition from manufacturing to services as an inevitable and desirable stage in the economic development of the nation, with the U.S. increasingly leaving manufacturing to other countries.
>
> We think this idea is mistaken. A large continental economy like the United States will not be able to function primarily as a producer of services in the foreseeable future. One reason is that it would have to rely on exports of services to pay for its imports, and this does not seem realistic. In 1987 gross U.S. exports of services were worth about $57 billion, whereas the total value of goods and services imported into the United States was about $550 billion . . . .
>
> The notion that the United States could eventually become almost exclusively a producer of services is all the more implausible when it is recognized that all of the manufactured goods now produced domestically would have to be imported (and hence paid for with exports of services) ... [while in fact] the long-term trend in the United States is toward increased demand for manufactured goods . . . .
>
> There is also reason to believe that if large sections of American manufacturing industry were ceded to other countries, high-wage non-manufacturing industries would follow them . . . .

> The United States thus has no choice but to continue competing in the world market for manufactures.

Turning back to the very slow growth in the stock of business equipment (less information processing) in the 1980s, we shall surely pay the long-run piper for this shortfall. We are perhaps paying it in the short run in the form of very sluggish recovery from a relatively mild recession.

That's the bad news. The good news is that Congress and the Administration can begin to turn the situation around. That turnaround involves meeting a long list of challenges, but the one of direct interest to this committee, is of course, tax policy.

TAXES AND BUSINESS INVESTMENT

Do taxes affect business investment decisions? That's a strange-sounding question to a corporate CEO, but the argument is still made that they do not. I regret to say that this argument is still given credence in some quarters. The only economic rationale I know supporting this view is the Keynesian hypothesis born in the depths of The Great Depression. Lord Keynes concluded that the primary (perhaps even sole) determinant of business investment was final demand for a company's products. This was understandable at a time when the prime bank lending rate was one-half of one percent, the Treasury bill rate one-twelfth of one percent, and tax burdens relatively low. In other words, capital costs were so low as to be no problem. The problem of the day was to stimulate consumer demand.

To be sure, forecasts of final demand are still very important in corporate decision-making as to capital expenditures -- but so are taxes. When we at Enron consider the initiation of a major investment project, we "scrub" the proposal until we have a pretty firm idea of the probable rate of return -- and that includes forecasts of final demand, degree of risk, etc. We then compare that so-called "internal rate of return" to the cost of the capital we will have to devote to the project. If the expected rate of return meets or exceeds the cost of capital, the project is in the ball park. If it falls short, the project is out of the game.

Taxes are <u>not</u> the most important element in our cost of capital; interest cost and cost of equity are most important, whether the financing is provided by attracting new debt or equity capital, or whether it is an opportunity cost incurred by financing the project out of cash flow. But, <u>at the margin</u>, the tax hit on the income from the projected investment <u>is</u> important. An ITC significantly reduces that tax hit and thus reduces the cost of capital for a project. It also provides additional cash flow for projects through an immediate reduction in federal tax liabilities.

How important are taxes in business capital costs? Professor John Shoven of Stanford estimates them to be about 15 to 33-1/3 percent of the total. Another way to view their importance is to note that the Library of Congress estimates that the increase in taxes on new investment in equipment after 1981 raised the capital cost of investing in that equipment by 23 percent.

WHICH TAX TO CUT?

Professor Shoven has also helped us decide which business tax to cut to promote productive investment. In a 1990 study, he concluded that the ITC is by far the most cost-effective approach to promoting business investment in equipment. Why is the ITC superior to a cut in the general corporate tax rate for this purpose? Because a company earns the ITC <u>only</u> if the new investment is made. On the other hand, a cut in the general corporate rate reduces the tax take on a huge volume of old, existing investment as well as new investment. In other words, the ITC works at the margin, where it is most effective.

But, some critics argue that accelerated deprection also works at the margin, by applying only to new investment, and is just as effective an as ITC. The important difference is that the ITC is a once-and-for-all cut in taxes that both reduces capital costs and enhances cash flow in the year the equipment is acquired. Accelerated depreciation is in essence an interest-free loan to the company, but it must be paid back through slower depreciation in later years. Capital costs will be reduced some, and cash flow enhanced, but not nearly so directly and effectively as with an ITC.

IS THE ITC A TAX "LOOPHOLE"?

Critics also charge that the ITC is a tax "loophole" for business, and that its restoration would renew the tax shelter business. Actually, a new ITC would simply help eliminate one of the three layers of taxation of business saving involved in our existing tax system. For every $1,000,000 in taxable income that Enron earns, it pays a tax of $340,000, regardless of the amount of that income that is retained (this is business saving) as opposed to being paid out as dividends. If those retained earnings are invested in a successful investment project, the earnings from that investment will be taxed at 34 percent. Then, finally, when we pay out dividends, our stockholders are taxed at their applicable individual rates. Or, if they sell the stock at a profit, they are taxed at the capital gains rate.

Enactment of an ITC will not wholly eliminate this unjustified and unwise overtaxation of saving and investment, but it will help ameliorate it.

Nor will restoration of the ITC in the targeted form we recommend revive the tax shelter business. To be sure, a new ITC would help some marginally profitable industries, such as airlines, obtain new and better airplanes through leasing them from financial service companies. But that is a long-standing finance mechanism which is widely accepted and hardly qualifies as a "tax shelter." To the extent tax shelters were built around the ITC before its repeal in 1986, they were primarily related to equipment in the offices of professionals, such as dentists and doctors. Such equipment would not be eligible for the targeted ITC which we support. Furthermore, if deemed necessary, limitations could be imposed to deny the ITC for partnerships which solicit investors in the usual form of tax shelters.

CUTTING THE COST OF THE ITC

The major problem with restoring the ITC is, of course, the cost -- upwards of $36 billion per year if enacted at the 10-percent rate and applying to all business equipment (as defined in the previously existing stature). This cost can be cut dramatically in two wholly legitimate ways, and that's what our proposal would contemplate.

First, targeting the ITC in the manner proposed will cut the cost by more than half. Simulations by the respected econometrician, Dr. Allen Sinai (see Table 3), indicate a reduction in the first full fiscal year (1993) from upwards of $36 billion per year to about $13 billion. Second, "scoring" the action dynamically rather than statically will further reduce the cost in the first full year to just $11 billion. I would strongly urge the dynamic scoring, Mr. Chairman, as would the vast majority of businessmen. It simply does not make sense to enact a measure -- such as restoration of the ITC -- which Congress believes will boost the economy and then not allow for the increase in revenues that increased activity will engender.

All in all, Mr. Chairman, these revenue costs are small relative to the strong boost to productive investment resulting from restoration of an effective ITC. Dr. Sinai estimates (Table 3) that the type of ITC proposed by the CCC would raise investment in targeted equipment by a cumulative 23 percent above baseline by 1997.

THE NEW ITC SHOULD BE PERMANENT AND NONINCREMENTAL

Mr. Chairman, some proponents of a new ITC have fashioned proposals that would conserve revenue either by making the credit temporary or applying it incrementally (that is, only the amount of new investment over that of some stipulated base period would receive the credit.) We are convinced that, reflecting the nature of business decision-making, a temporary ITC would do little more than move ahead in time some spending that would take place later, thus doing little at all for long-term growth.

We are especially opposed to the idea of an incremental ITC. Our Coalition consists of aggressive investors -- companies that have been willing to risk the ire of stockholders who favor increased dividends over the retained earnings that are the source of much corporate investment. An incremental ITC would unduly reward the sluggish investors of earlier years and penalize companies which have kept their investment up.

That's simply not fair.

CONCLUSION

Mr. Chairman, the record, economic analysis, and common sense support the view that we need a new ITC. It is tried and true. It has many friends in Congress and is truly nonpartisan. Targeting the credit to productive equipment will sharply reduce the cost but give up very little of its strong "bang-for-the-buck" impact on business investment in productive equipment.

Mr. Chairman, the Coalition for Competitive Capital recommends enactment of a permanent, targeted 10-percent investment tax credit at the earliest possible date.

Thank you very much.

APPENDIX A

COALITION FOR COMPETITIVE CAPITAL
Membership List

Mr. James D. Woods
Chairman, President & CEO
Baker Hughes Inc.
3900 Essex Lane, #1200
Houston, TX 77027

Mr. William D. Ruckelshaus
Chairman & CEO
Browning-Ferris Industries, Inc.
757 North Eldridge
Houston, TX 77253

Mr. Gerald Grinstein
Chairman, President & CEO
Burlington Northern Inc.
3800 Continental Plaza, 777 Main Street
Fort Worth, TX 76102

Mr. John M. Hennessy
President & CEO
CS First Boston, Inc.
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Mr. James J. O'Connor
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Mr. Kenneth L. Lay
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Mr. Thomas H. Cruikshank
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Mr. Edward F. Mitchell
President & CEO
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Mr. James E. Rogers, Jr.
Chairman & CEO
PSI Resources
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Mr. Richard A. Clarke
Chairman & CEO
Pacific Gas and Electric Company
77 Beale Street
San Francisco, CA 94106

Mr. Ed Addison
President & CEO
The Southern Company
64 Perimeter Center
Atlanta, GA 30346

Mr. Robert H. Campbell
President & CEO
Sun Company, Inc.
1801 Market Street
Philadelphia, PA 19103

Mr. Michael Walsh
President
Tenneco Inc.
1010 Milam Street
Houston, TX 77002

Mr. Joseph H. Williams
Chairman and CEO
Williams Companies, Inc.
One Williams Center
Tulsa, OK 74172

APPENDIX B

Eligible Property (Excluded vs. Included)

Excluded

Buildings & structural components, and "section 1250 class property" in general.

Any machinery & equipment used in the following business activities:

- Retail and wholesale trade
- Services businesses in general (including banking, financial, insurance, legal, medical and accounting)
- Recreation activities
- Theme and amusement parks

The following machinery equipment — by asset type — used in any business activity:

- Office furniture, fixtures, and equipment
- Office-type data handling equipment (except computers used for certain types of research)

Illustrative examples of excluded assets:

- Store counters, display cases, racks & shelves
- Billboards & signs
- Regular air conditioners
- Restaurant tables & kitchen equipment
- Barber chairs
- Hotel beds & furniture
- Regular light fixtures

Included

All machinery & equipment integral to (i) producing products or energy in the U.S. or performing relating research, or (ii) providing essential transportation , communications, waste disposal services:

Illustrative examples — machinery & equipment used in any of the following activities:

- Agriculture and fisheries
- Timber cutting, saw milling and manufacture of wood products
- Mining and extraction
- Oil & gas exploration, drilling & production
- Petroleum refining
- Grain milling
- Construction
- Steelmaking & manufacture of non-ferrous metals
- Metal fabrication
- Pulp & paper production
- Automobile & vehicle production
- Manufacture of chemicals
- Production of rubber & rubber products
- Shoe & leather products
- Manufacture of plastic & plastic products
- Production of medical supplies & drugs
- Production of glass, stone, and clay products
- Foundry work
- Machine tool production

Excluded

Dental chairs & drills

Checkwriters

Automatic-teller machines

Vending machines

Bank vaults

Word processors

Photocopiers

Desk-top computers (except if used for certain types of research)

Office furniture, fixtures, & equipment, such as (a) oriental rugs (b) art work (c) desks (d) chairs

Car washes

Books in a law office

Films & tapes

Escalators

Elevators

Carousels

Rollercoasters

Pool & billiard tables & equipment

Bowling balls & pinsetting machines

Ski lifts

Theater seats & other theatrical equipment

Motion picture projection equipment

Exercise equipment

Tennis nets

Plus: an array of other similar assets not integral to production, manufacturing, etc.

Included

Manufacture of electronic, electrical & other mechanical products

Manufacture of food products

Aerospace manufacture

Shipbuilding

Production and transmission of electricity, gas & steam

Air and land transportation services

Telephone, telegraph & communications services

Further illustrative examples — specific assets included:

Airplanes

Continuous casters (steel)

Railroad equipment & track

Drilling rigs

Computers used for research pertaining to included activities

Computers that run assembly lines or are otherwise integral to production or manufacturing

Farm tractors

Laboratory equipment

Looms

Printing presses

Rolling mills

Auto assembly lines

Lathes

Trucks, buses, taxis used in passenger or freight hauling businesses or integral to production, manufacturing or extraction

APPENDIX C

American Council for Capital Formation
Center for Policy Research

October 1990

SPECIAL REPORT

Equipment Investment Spurs Economic Growth

A new study by Harvard University professors J. Bradford De Long and Lawrence H. Summers finds a strong link between investment in producers' durable equipment and economic growth.[1] Highlights of their study are presented below. They find that each one percent of gross domestic product (GDP) invested in equipment causes GDP to increase by one-third of a percentage point per year. This is a much stronger association than can be found between growth and any of the other components of investment.

Traditional Economic Growth Theory

Economic historians credit industrialization and mechanization with the boom in European economic growth that began in the 1760s. Modern quantitative studies of economic growth, however, have tended to downplay the role of mechanization, according to De Long and Summers. Economists such as Robert Solow and Edward F. Denison, and others, have typically concluded that capital accumulation accounts for only a relatively small fraction of productivity growth in individual countries, or of differences across countries. Capital accumulation, in the view of Solow and others, can make only a modest contribution to accelerating growth. Even a doubling of the U.S. net private investment rate would, according to standard estimates, raise the growth rate of real income by less than half a percentage point per year.

The De Long and Summers study provides quantitative evidence in support of the older, traditional view that the accumulation of machinery is a prime determinant of economic growth.

Results of the Study

De Long and Summers analyze the effect of electric and non-electric equipment investment on economic growth using data from the United Nations International Comparison Project for a sample of twenty-five high-productivity countries.[2] They reason that the centrality of machinery in historical discussions of growth suggests the importance of disaggregating total investment in considering its relation to economic growth. If machinery and structures contribute differently to growth, then analyses of the relationship between total capital accumulation (equipment plus structures) and growth are likely to be very misleading.

The De Long and Summers study shows that nations that invested heavily in equipment relative to other nations at the same stage of economic development enjoyed rapid growth over the 1960–1985 period (see Figure 1). In evaluating the contribution of equipment investment to growth, the authors hold constant labor force growth rates, the share of GDP devoted to non-equipment investment, and the level of GDP per worker. The results of the regressions underlying Figure 1 imply that an increase of 3 percentage points in the share of GDP devoted to equipment investment leads to an increase in the growth of GDP per worker of 1.92 percent per year, which cumulates to a 29 percent difference over the twenty-five years of the sample. This means, for example, that differences in equipment investment account for essentially all of the extraordinary growth performance of Japan relative to the sample as a whole. Japan achieved a relative GDP per worker growth rate edge of 2.2 percent per year over 1960–1985 relative to the average, and a 5 percent per year edge relative to Argentina, in both cases, more than four-fifths of this difference is accounted for by Japan's high relative quantity of equipment investment.

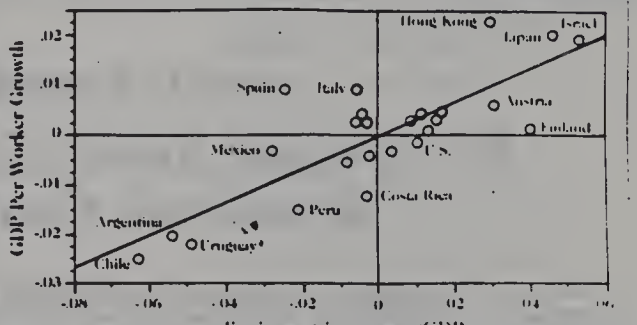
De Long and Summers conclude that one reason to believe that equipment investment causes growth, rather than to believe that growth causes investment, is that t

[1] J. Bradford De Long and Lawrence H. Summers, "Equipment Investment and Economic Growth," mimeographed (Cambridge, Mass.: Harvard University and National Bureau of Economic Research, September 1990).

[2] High-productivity countries are defined as those whose 1960 levels of GDP per worker exceed 25 percent of the U.S. level. Economic growth is defined as the growth rate of GDP per worker, measured in international dollars.

growth caused investment there would be a similar association between structures investment and growth. Rapid economic growth raises the potential profits from investing in equipment and thus induces firms to invest in order to establish and entrench market positions, but it also raises the profits earned by structures. Favorably located land is in fixed supply, and larger structures economize on the use of such land. One might therefore imagine that faster economic growth would tend to shift the use of savings away from producers' equipment and toward structures. Yet it is equipment investment, not structures investment, that is associated with rapid growth in their study.

Figure 1
Economic Growth and Equipment Investment, 1960–1985



Conclusions and Policy Implications

The study makes a persuasive case for a strong association between equipment investment and growth. The relationship between rates of equipment investment and growth accounts for a substantial part of the variation in rates of growth among the countries in their sample. The authors believe that previous studies, which failed to find much correlation between capital accumulation and economic growth, were flawed because they did not disaggregate equipment from structures investment.

The study shows that the benefit to society as a whole—the social return—from equipment investment is at least 30 percent per year. Much of this return accrues to society rather than to private investors. If these results stand up to scrutiny, they have obvious implications. The gains from raising equipment investment through tax or other incentives dwarf the losses that might result from differences in effective tax rates on the various components of investment. A 20-percentage-point-per-year wedge between the social return to equipment and other investment has implications for all policies affecting saving and capital allocation.

De Long and Summers also note that the finding that equipment investment is so important for growth suggests an explanation for the striking differences in economic performance realized by nations with "interventionist" governments that have tried to jump start economic growth. The key difference between countries ruled by "interventionist" governments in South America and East Asia lies in their quantities of equipment investment. Why is it that South America (with the exception of Brazil) and Africa have for the most part had slow economic growth, while East Asian economies with activist governments have done so well? De Long and Summers suggest that the poor performers have confused support for *industrialization* with support for *industrialists*. Policies that try to increase the health of the equipment sector by enriching producing industrialists end up raising prices and reducing quantities and thus are counterproductive—even though existing industrialists are happy with such policies. Government policies that increase the quantity of equipment investment by encouraging purchases appear to have been more successful. The divergence in the relative quantity and price structures for equipment in these countries carries an important insight into what a successful "industrial policy" is and how it should be implemented.

The study suggests that U.S. policymakers would be well advised to consider tax incentives that target investment in equipment because of the positive impact on economic growth.

The ACCF Center for Policy Research is the education and research affiliate of the American Council for Capital Formation. Its mandate is to promote an understanding by the public of the importance of capital formation to the economy. For more information or to receive additional copies of this *Special Report*, please contact: ACCF Center for Policy Research, 1850 K Street, N.W., Suite 400, Washington, D.C. 20006 (202) 293-5811.

TABLE 1

Saving and Investment as a Percent of Gross Domestic Product, 1973-1989

	United States	Canada	Japan	France	West Germany	United Kingdom
SAVING						
Net Saving [1]	4.6%	9.0%	18.9%	8.9%	10.9%	5.1%
Personal Saving [2]	5.5%	7.2%	12.3%	7.5%	8.1%	3.1%
Gross Saving (net saving plus consumption of fixed capital) [3]	17.2%	20.5%	32.3%	21.2%	22.9%	16.7%
INVESTMENT						
Gross Non-Residential Fixed Capital Formation	13.2%	15.6%	23.7%	14.8%	14.7%	14.2%
Gross Fixed Capital Formation	17.9%	21.8%	29.9%	21.0%	20.6%	17.9%

Source: Derived from National Accounts, Vol. II, 1973-1985 and 1977-1989, Organization for Economic Co-Operation and Development (OECD), 1987 and 1991 eds. Prepared by The American Council for Capital Formation Center for Policy Research, October 1991.

[1] The main components of the OECD definition of net saving are: personal saving, business saving (undistributed corporate profits), and government saving (or dissaving). The OECD definition of net saving differs from that used in the National Income and Product Accounts published by the Department of Commerce primarily because of the treatment of government capital formation.

[2] Personal saving is comprised of household saving and private unincorporated enterprise.

[3] The main components of the OECD definition of consumption of fixed capital are the capital consumption allowances (depreciation charges) for both the private and the government sector.

TABLE 2

Growth in the Net Capital Stock by Type (annual percent change in 1982 dollars)

	1950-59	1960-69	1970-79	1980-89	1989 Level (billions of 1982 dollars)
Total	3.8	4.3	3.6	3.0	3830.4
Equipment	4.7	4.9	5.0	4.1	2012.8
Equipment Less Information Processing	4.2	4.9	4.3	1.6	1339.8
Structures	3.3	3.8	2.5	1.9	1817.6

Source: Charles Steindel, "Recent Trends in Capital Formation," in U.S. Investment Trends: Impact on Productivity, Competitiveness, and Growth, (Washington, D.C.: American Council for Capital Formation Center for Policy Research, March 1991). Table modified by ACCF Center for Policy Research.

TABLE 3

Macroeconomic Effects of a Targeted 10 Percent Investment Tax Credit (fiscal years 1992-1997)
(Change from baseline)

	1992	1993	1994	1995	1996	1997	1992-1997 (cumulative)
Targeted 10.0 Percent Investment Tax Credit							
A. Producers Durable Equipment							
1. Total (1982 $)	2.2	6.7	8.1	9.0	9.7	9.7	45.4
2. Total (% change from baseline)	0.6	1.7	2.0	2.1	2.1	2.0	10.5
3. Targeted Equipment (1982 $)	1.8	4.7	5.4	6.0	6.3	6.5	30.7
4. Targeted Equipment (% change from baseline)	1.5	3.7	4.1	4.4	4.5	4.4	22.6
B. User Cost of Capital (yearly and average annual change)	-7.3	-11.3	-11.6	-11.8	-12.1	-12.2	-11.8[1]
C. Impact on Federal Tax Revenue							
1. Federal Tax Revenue After Macro Feedback	-6.7	-11.0	-12.8	-13.8	-15.1	-17.0	-76.4
2. Static Revenue Loss	-8.0	-13.1	-14.5	-16.1	-17.8	-19.4	-88.9
D. Employment (Millions of Persons)	0.084	0.183	0.132	0.125	0.130	0.078	0.732

Source: Dr. Allen Sinai using Sinai-Boston Model of the U.S. Economy. Prepared by the ACCF Center for Policy Research, February, 1992.

[1] Average capital cost reduction over 1993-1997 period

STATEMENT OF THE COALITION OF INDEPENDENT CASUALTY COMPANIES OF AMERICA

I. INTRODUCTION

The Coalition of Independent Casualty Companies of America ("CICCA") is an association of small property and casualty insurance companies incorporated in the District of Columbia. It has members located in over 35 states and the District of Columbia. CICCA commends Chairman Bentsen for holding hearings concerning the U.S. economy and economic growth.

CICCA and its members are concerned with the effect of the Tax Reform Act of 1986 on small property and casualty insurance companies, particularly as compared with the treatment afforded small life insurance companies. In particular, CICCA and its members are concerned that a failure to address these problems in the near future will make it difficult, if not impossible, for small property and casualty companies to assist, as they historically have, with the next property and casualty insurance availability crisis. If this crisis occurs just as the Country is pulling itself out of the current economic downturn, the consequences could be highly negative.

This statement will contrast the tax treatment of small life insurance companies and small property and casualty insurance companies and the context in which such different treatment arose. It will highlight the impact of these provisions on small, growing property and casualty companies, indicating that the consequence is to produce dramatically high effective tax rates (frequently in excess of 100 percent) for such companies as compared with the statutory income they must report to their state regulators for solvency analysis and other purposes. It will suggest that the failure to address these problems could have highly negative effects on the U.S. economy if the next property and casualty availability crisis occurs just as the economy is beginning to recover. Since there is no policy reason justifying the less favorable tax treatment of small property and casualty companies in comparison to small life insurance companies, and because significant negative effects for the U.S. economy could occur under the current situation, CICCA recommends that small property and casualty companies be allowed a small company deduction like that which applies to small life insurance companies. This would be accomplished by enacting S. 1314, the "Small Property and Casualty Insurance Company Equity Act of 1991," originally introduced by Senator Boren.

II. CURRENT LAW

A. Property and Casualty Insurance Companies.

Property and casualty insurance companies pay income tax on their taxable income at the rates prescribed by section 11 of the Internal Revenue Code of 1986 (the "Code"). Code § 831. The taxable income of property and casualty insurance companies is computed under the rules provided in part II of subpart L of the Code, which partially take into account the need for property and casualty insurance companies to maintain loss reserves and the other special circumstances that affect property and casualty insurance companies. Notwithstanding these provisions, it is very difficult for small property and casualty companies to grow as a result of surplus requirements restricting the amount of premiums which may be written and the inherently risky business in which they are engaged. In addition, an unusual loss occurrence, e.g., an earthquake, is more likely to financially cripple a small property and casualty company than is the case for larger companies which have more flexibility in diversifying

their risks. Small property and casualty companies, nevertheless, play a significant role in the property and casualty industry, providing competition for large companies and, in some cases, providing coverage where large companies are either unable or unwilling to provide such coverage. Their role can be particularly critical when coverage shortages arise as in the middle 1980s.

A very limited class of small property and casualty companies are either exempted from tax by section 501(c)(15) of the Code (those property and casualty companies, generally, whose yearly premiums do not exceed $350,000) or can elect under section 832(b) of the Code to be taxed only on their taxable investment income (those property and casualty companies, generally, whose yearly premium income is between $350,000 and $1,200,000). Even if the election under section 832(b) is utilized, electing companies are required to compute under the regular method for purposes of computing their alternative minimum tax liability.

The above provisions were inserted in the Code by the Tax Reform Act of 1986, to replace several provisions that previously applied to small mutual property and casualty companies. As is indicated below, these limited provisions are not comparable to the small company provisions applicable to small life insurance companies, notwithstanding the fact that predicting losses for property and casualty insurance companies is more difficult than for life insurance companies which are able to rely upon actuarial tables and which are not subject to the greater risks and uncertainties associated with property and casualty coverage.

The Tax Reform Act of 1986 included a variety of other changes in the tax treatment of the property and casualty industry. These changes have resulted in a significant increase in the tax burden of small property and casualty insurance companies, making it especially difficult for them to attract and retain capital, particularly as compared with small life insurance companies.

B. CICCA Study Analyzing Effect of Current Law on Small Companies.

CICCA has commissioned a study to analyze the impact of the current law on property and casualty income tax provisions on small, growing property and casualty companies. While the results are preliminary, they indicate that there is a direct relationship between the rate of growth of these companies and the magnitude of the Federal income tax rate as compared with statutory income they must report to their state regulators for solvency analysis and other purposes. In most of the situations other than where there is no rate of growth, the effective tax rate frequently exceeds 100 percent and almost always exceeds 50 percent. In those situations where the effective rate exceeds 100 percent, one of the obvious direct consequences is that the capital and surplus of the company is declining notwithstanding the fact that the company has statutory income prior to the effects of Federal income tax. Set forth immediately below is a summary of the preliminary results of the study indicating the effective tax rates on statutory income for each of the growth scenarios examined by the study.

Summary of Effective Tax Rate on State Statutory Income as a Function of Rate of Premium Growth

Tax Year	1	2	3	4	5
			(Tax Rate)		
Rate of Premium Growth					
0%	130%	86%	58%	45%	38%
10%	130%	89%	64%	53%	47%
25%	130%	92%	70%	64%	56%
50%	130%	98%	80%	73%	70%
100%	130%	105%	Infinite	654%	Infinite
200%	130%	93%	374%	87%	104%

The preliminary results of the study clearly demonstrate that the effective rate of tax as compared with state statutory income increases as the rate of premium growth increases. Moreover, in companies with moderate to significant rates of growth, the rate of tax as a percentage of statutory income exceeds 100 percent on a regular basis. The results are clearly supported by the actual situations which many CICCA member companies are facing.

The preliminary results of the study indicate that the current Federal income tax rules will make it highly unlikely that small property and casualty insurance companies will be able, or willing, to rapidly increase their capacity when the next insurance availability crisis occurs. Historically, small property and casualty insurance companies have increased their capacity in response to coverage shortages. If this does not occur in the next coverage crisis, the crisis could be far deeper than has ever been observed in the past. Thus, serious consideration should be given to the enactment of pending Federal income tax legislation, H.R. 2768, which would extend to small property and casualty insurance companies the same treatment currently afforded to small life insurance companies. Enactment of H.R. 2768 would significantly address the extraordinarily high rates of tax compared with state statutory income currently facing small property and casualty insurance companies.

III. IMPLICATIONS OF THE CURRENT TAX STRUCTURE FOR THE NEXT PROPERTY AND CASUALTY INSURANCE AVAILABILITY CRISIS

Historically, the property and casualty insurance industry has always been cyclical in nature. During the period of losses, the total surplus of the industry contracts. The typical consequence of this phenomenon is that periods of availability shortages arise. What has occurred generally in the past is that small property and casualty insurance companies have responded to these availability shortages by increasing the amount of their capacity. This is typically done through either incorporation of new small property and casualty insurance companies, or through addition of capital to existing companies.

The CICCA study preliminarily indicates that the effective tax rate as compared with state statutory income increases as the rate of growth of a company rises. As a consequence, it will be extremely difficult in the next availability crisis to convince potential investors to contribute capital to new or existing small property and casualty insurance companies. The return on investment compared with other small potential uses of capital is unlikely to make investment in a property and casualty insurance company sufficiently attractive. As a consequence, it can be anticipated that under the current Federal income tax structure, the next property and casualty availability crisis is likely to be far more severe than that which has been experienced in the past.

IV. PENDING LEGISLATIVE PROPOSALS WHICH WOULD ADDRESS PROBLEMS IDENTIFIED BY THE STUDY

Under current Federal income tax rules, small life insurance companies, defined as those with less than $500 million of assets, are entitled to a special small company deduction. This provision was enacted as part of the 1984 legislation rewriting the tax rules applicable to life insurance companies. This provision was intended to assist small life insurance companies in competing and growing in the life insurance industry. The provision entitles such companies to a 60 percent exclusion from what would otherwise be taxable income up to $3 million of income. The exclusion phases out between $3 million of income and $15 million of income.

Legislation is currently pending in the U.S. Senate which would extend the small life insurance company provision to small property and casualty insurance companies. This legislation is S. 1314, the "Small Property and Casualty Insurance Company Equity Act of 1991." Similar legislation is pending in the House as H.R. 2768. Enactment of this legislation would significantly address the problems currently faced by small, growing property and casualty insurance companies by offsetting, at least partially, the high effective tax rate on statutory income currently faced under existing tax rules. Enactment of this legislation would serve to significantly reduce the negative incentives which exist to contribute capital to new or existing small property and casualty insurance companies. Moreover, enactment of these provisions would make it substantially more likely that small property and casualty insurance companies would be able to play a significant role in addressing the next availability crisis.

If the U.S. economy begins to recover, or is in a full blown recovery, when the next property and casualty availability crisis occurs, the current tax rules are likely to make it impossible for small property and casualty companies to respond to the crisis. The negative effect on such a recovery, and for the Country, could be severe. Enactment of H.R. 2768 will avert such an undesirable situation and should occur as part of any economic recovery package.

STATEMENT OF THE COLLEGE OF AMERICAN PATHOLOGISTS

The College of American Pathologists appreciates the opportunity to comment on Fiscal Year 1993 budget proposals being considered by the Senate Finance Committee. The College is a national medical specialty society representing 12,000 physicians who are certified by the American Board of Pathology. CAP members practice their specialty in community hospitals, independent medical laboratories, academic medical facilities, medical examiner/coroner offices, and federal and state health facilities.

The Medicare program has sustained significant budget cuts over the past years. Laboratory medicine, in particular, has been the target of numerous and repeated reductions in Medicare payment. Since 1984 Medicare payment for clinical laboratory testing and pathology services has been subject to national limitations on fee schedule amounts, cuts in national limitation amounts, foregone or reduced inflation updates, and reductions in prevailing charges.

As a result of the budget agreement reached in 1990, clinical laboratories are subject to additional cuts in 1992 and 1993 by imposing a 2% cap on clinical laboratory fee schedule updates to reflect inflation. The enclosed Attachment further details these and other reductions that have been imposed since 1984.

Despite these reductions, the Administration is recommending further cuts in clinical laboratory services. The Administration proposes a reduction in the national cap on carrier fee schedules from 88 percent of the fee schedule median to 76 percent of the median. The already limited CPI updates would be potentially further limited by revising the update "to more accurately reflect current market factors."

The College urges the Committee to reject these ill-conceived proposals for the following reasons:

The Administration's Proposals Are Inequitable

Since 1984 clinical laboratories have been subjected to repeated cuts. The national fee schedule caps were initially set at 115% of the median of all fee schedules in 1986. They were subsequently reduced to 100% of the median in 1988, to 93% in 1990 and 88% in 1991. At the same time there have been freezes and caps on scheduled increases intended to adjust the fee schedules to reflect inflation in the economy.

The Fiscal Year 1993 proposals would reduce payments by $310 million in the first year and by almost $4 billion over five years. Clinical laboratory services which account for a relatively small portion of total Medicare Part B spending (less than 10%) would be expected to absorb almost 75 percent of the proposed Part B reductions. This is unrealistic and inequitable.

Drastic Reductions are Proposed Despite Federally Required Regulatory Cost Increases

Reduced reimbursement is being proposed at a time when the cost of laboratory testing is increasing because of other government initiatives. The implementation of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) will impose additional costs on laboratories by requiring more stringent proficiency testing and other quality control measures. New federal cytology workload limits and other requirements will raise the cost of cytology services. In addition recent Occupational Safety and Health Administration standards to protect laboratory workers from blood borne pathogens will raise costs. The College supports reasonable requirements to assure quality in laboratory services and to protect workers. It is unreasonable to expect physicians, hospitals and independent laboratories to meet these standards and, at the same time, impose severe fee schedule reductions.

Summary

The College of American Pathologists urges the Senate Finance Committee to reject the Administration's proposals for Medicare cuts in Fiscal Year 1993 — cuts that would be in addition to the reductions already scheduled in a five-year comprehensive deficit reduction plan. Although less than 10 percent of all Part B expenditures go for clinical laboratory services, approximately 75 percent of the savings projected under the current proposal would come from these services. This is clearly unfair to clinical laboratories, especially in view of the increasing regulatory costs that these entities are now facing.

College of American Pathologists

ATTACHMENT

Major Restrictions In Payment for Medicare Clinical Laboratory Services:

July 1984: Clinical Laboratory Fee Schedule Established

- Carrier fee schedules were implemented for clinical laboratory services performed in hospitals for outpatients, in physicians' offices, and in independent laboratories. Payments were set at 60% of prevailing charges for independent laboratories and physicians' offices; and at 62% for hospital outpatient services.
- Mandatory assignment was instituted for independent laboratories and hospitals.

July 1, 1986: Fee Schedule Caps Established

- Carrier fee schedule amounts were capped at 115% of the median of all fee schedule amounts.

January 1, 1987: Payments Reduced; Assignment Expanded

- Hospital fee schedule amounts were reduced from 62% to 60% of the prevailing charge, except for hospitals with 24 hour, 7 day a week emergency room services.
- Physicians' office laboratories were required to accept assignment.

January 1, 1988: Update in Fee Schedule Eliminated

- Laboratory fee schedule inflation updates were eliminated.

April 1, 1988: Payments Reduced

- The 2% differential was eliminated for all hospital laboratories except those operating qualified emergency rooms in sole community hospitals.
- Fee schedules for high volume tests were reduced by 8.3%.
- The fee schedule caps were reduced from 115% to 100% of the median of all fee schedules.

January 1, 1990: Payments Reduced

- The fee schedule caps were reduced from 100% to 93% of the median of all fee schedules.

January 1, 1991: Update Limited; Payments Reduced

- The fee schedule caps were reduced from 93% to 88% of the median of all fee schedules.
- Laboratory fee schedule inflation updates were limited to 2% (4.3% was scheduled).

January 1992 and 1993: Updates Limited

- Laboratory fee schedule inflation updates are limited to 2% regardless of inflation.

Statement of the Health Industry Distributors Association

I. INTRODUCTION: HIDA

The Health Industry Distributors Association is the national association of health and medical products distribution firms. Created in Chicago in 1902 by a group of medical products business people, HIDA now represents over 900 wholesale and retail distributors with nearly 2000 locations.

HIDA members include a broad range of medical products distributors -- billion dollar multi-location national companies and neighborhood stores, chains and independents. HIDA members provide value added distribution services to virtually every hospital, physician office, nursing home, clinic and other health care sites (other than Veterans Administration and Department of Defense) in the nation, and for a growing number of patients directly for use in their home.

II. HEALTH AND MEDICAL PRODUCTS DISTRIBUTION

A. Value Added Services

Ensuring that the right products arrive at the right places, in the right quantity, at the right times, in the right condition -- all at the least cost -- is the challenge that faces health care distributors, manufacturers, and providers. This chain of product and information exchanges must work well to meet complex and challenging logistical needs every day. This process is called materials management. In their 1990 research project sponsored by the HIDA Educational Foundation, Arthur Andersen consulting estimated total materials management costs at 25 to 30 percent of a typical hospital's budget. (See Attachment A, "Stockless Materials Management: How It Fits Into the Healthcare Cost Puzzle", Arthur Andersen 1990). We estimate that other providers may spend more to provide these non-patient care functions.

HIDA members are the traditional pipeline through which medical supplies and equipment flow to the final users in all segments of health care. Medical products distribution is the link between the manufacturer that produces the product and the ultimate consumer of such products. Distribution involves moving medical and surgical products -- from cardiac catheters to hip implants to bandages -- from the point of manufacture to the point of use in the hospital, nursing home, physician's office, clinic, by the patient in their home, or wherever health care is provided.

This path of product movement is quite complex, and includes storage, handling, and transportation activities at each location in the chain. It encompasses complex communications for product tracking for recalls, inventory and production needs, and the processing of financial transactions that accompany payment, rebates, third-party reimbursement, credit, and other activities.

Distributors have heavily invested in technology to efficiently provide warehousing, transportation and other logistical services. Billing and collection from hospitals, nursing homes and home care patients are standard distribution functions. In fact, distributors today carry a major portion of the credit extended to hospitals, nursing homes, and physicians, as well as to Medicare for most durable medical equipment (DME) provided in the home. Nationwide, distributors are financing hospitals for 45 to 60 days on average, and up to six months in some parts of the country. Distributors also perform value added services such as equipment repair and maintenance, product in-service, training, and installation.

Health and medical products distributors are focused on removing cost from the medical products supply channel.

Internally, distributors are squeezing cost out of their own operations by investing in systems and technology that utilize EDI (electronic data interchange) paperless transactions, maximize fill-rates, reduce handling costs, and control excess inventory. In the past three years, hospital distributors have reduced their total operating expenses almost 22% (See 1988-1991 HIDA Surveys of Distributor Financial Performance and Market Condition).

At the same time, medical products distributors have been offering new and innovative services to customers to help reduce their costs as well. For example, hospitals

and nursing homes look for ways to reduce their labor costs. Through value added services such as product bar-coding, distributors help the provider reduce the labor involved in tracking inventory use for patient care, and more efficient patient charge systems. EDI systems used by home medical equipment suppliers permit Medicare carriers to reduce costs of paperwork and human error in processing DME claims.

Asset management programs like consignment, "Just-In-Time", and "Stockless" are helping hospitals, nursing homes and other providers to convert inventory assets to cash, and warehouse space into patient care facilities.

A national or system wide value such as the "Just-In-Time" or stockless programs developed by distributors stems from the fact that inventory is removed from the total supply system. By pooling stocks across several hospitals rather than storing them in the central storeroom of each hospital, a distributor can provide the same level of product availability at reduced total inventory levels to the system.

"Just-In-Time" and "Stockless" programs are proven inventory reducers. A Florida hospital, for instance, cut its medical products inventory investment by more than one million dollars through "Just-In-Time" delivery agreements with its prime vendors. (See Stockless Materials Management: How It Fits Into the Healthcare Cost Puzzle, Arthur Anderson & Co., 1991.) Stockless programs go a step beyond "Just-In-Time" to eliminate -- not just reduce -- the hospital or nursing homes central storeroom inventory. The distributor runs a "pick and pack" operation for the hospital driven by floor inventory replenishment order, as if it were running the product delivery operation out of the hospital's own storeroom. This means the hospital assigns to the distributor the complete delivery process, from warehouse to nurse's station. (See From Producer To Patient: Valuing the Medical Products Distribution Chain," Ernst and Whinney, 1987).

It is noteworthy that these innovations in product distribution developed by the private sector, particularly stockless programs, are now being considered by the federal distribution systems operated by the Department of Defense and Veterans Administration health care programs.

These asset management programs also remove ongoing costly and unnecessary duplications in the medical products supply channel. Medical facilities have realized that physicians, nurses, and other health professionals should not be spending their valuable and expensive time processing supplies and related paperwork, and are therefore assigning some of these functions to distributors who perform these functions more efficiently.

Through the HIDA Educational Foundation, our industry is providing ongoing education and research to further develop innovative and efficient distribution services that bring value to the entire system by removing unnecessary costs.

Home Medical Equipment, Supplies and Services

Health and medical products distributed by HIDA members directly to patients in their home also involve a very high level of service. These home medical equipment (HME) dealers not only deliver products from the inventory in their warehouse necessary to allow someone to be cared for at home, the dealer also is responsible for determining a patient's equipment needs, training the patient or family in the use of the equipment, servicing the equipment through the period of need, and retrieving the item when it is no longer needed. Equipment acquisition is only a small part of the overall costs to a HME dealer; the majority of the costs for HME are associated with the service component of the product, which is very labor intensive (See The Home Medical Equipment Industry: An Examination of the Industry's Expense Structure, Lewin/ICF, July 26, 1990.)

The pressure on the providers to reduce length of inpatient stay as well as the development by HIDA members of locally managed home medical equipment services that allow for more care in the home are largely responsible for hospital payment savings. Full realization of the potential of home medical equipment services can achieve significant cost savings as well as improve patient satisfaction. (See Attachment C: "Economic Analysis of Home Medical Equipment Services," Lewin/ICF May 1991.)

B. Distribution: Value Added Service To Health Care

The profound changes in the health care industry that have occurred in the last decade, such as the advent of hospital prospective payment (DRGs) and rapid developments

in technology for use by patients in their home have had an enormous impact on the way medical products are delivered. Any further changes in the health care delivery system will also affect the medical products distribution industry as well.

Americans spend more on health care because, in part, we want more of it and we can afford it. But we also spend more because we waste more. We have created a wide variety of laws, regulations, and practices that allow us to satisfy our health care desires, but which have also created incentives to spend more health care dollars on items and services which give us little value.

The United States is spending over 12 percent of its gross national product on health care -- about 650 billion dollars per year. Not only is the level of spending high and rising, but there is also concern about the value of the services being purchased. Whatever health care spending level we deem appropriate, we must ensure that we receive value for every health care dollar we spend.

Foremost, we must focus on eliminating waste. We have described earlier value added services distributors provide and the potential these services have for reducing health system costs. Many of these savings are already occurring although barriers and disincentives continue.

Health care cost efficiency and receiving value for every health care dollar we spend must be part of every segment of our nation's health delivery system including government operated health systems.

HIDA members believe that structural innovation and process improvements leading to the elimination of waste in the form of excess administrative costs can produce the needed economies in our health care system.

Many of our members are small companies with under 10 million dollars in annual revenues. As employers purchasing healthcare benefits and as taxpayers supporting government healthcare systems, we are convinced that many opportunities exist to remove unnecessary costs from health care.

In plain language, what we are talking about is waste. Approximately one half of all health care spending goes into administrative costs. These functions do not provide health care to anyone. To the extent they are a necessary part of the system, they should be consolidated and streamlined. Those functions which are found to add little value in relation to their cost should be eliminated.

Working with our provider, manufacturer and commercial payor partners in the health and medical product supply chain, we will continue to seek and implement measures to remove costs from our systems. We support and encourage the efforts of other health care segments including Medicare, Veterans Administration and Department of Defense to do the same.

III. NATIONAL HEALTH REFORM

A. Basic Principles

HIDA supports an effective, affordable, free enterprise solution to the health care cost crisis facing the Nation. Problems of cost and financing have limited access to quality health care for the millions of Americans who do not now have health care coverage; and they jeopardize future access for the additional millions of Americans whose insurance coverage is at risk due to rising costs or expensive personal health problems.

HIDA strongly believes that viable solutions to the health care crisis must address the problems of cost and access in tandem. We also believe that solutions must be immediate, substantive, incremental, based on market principles, relying on a mixture of incentives and structural and legislative reforms.

HIDA is a Steering Committee member of the Healthcare Equity Action League (HEAL), a coalition of over 360 major firms and organizations representing more than one million employers and 35 million employees. This diverse group includes large and small businesses, corporations, associations, health care providers and insurers.

HEAL members are united by concern over the current states of the nation's health care system and how that system can be reformed to better service the public. HIDA and other HEAL members are dedicated to making health care available and affordable to all Americans, so they can obtain coverage and keep it.

Senate Finance Committee Lloyd Bentsen's health reform bill (S. 1872) embraces substantial elements of our position. Portions of this proposal can and should be enacted now. Following are specific positive steps we recommend be implemented as expeditiously as possible:

* Full Federal Preemption of State Health Insurance Mandates
* Preemption of state laws which restrict managed care and Cost sharing
* Reform of Insurance Underwriting
* Reform of Medical Malpractice Provisions
* Full Deductibility of Health Insurance Premiums for All Businesses
* Consumer Empowerment and Individual Responsibility
* Health Care Costs Must Be Brought Under Control

B. Home Care -- A Vital Component

1. Home Care Coalition

A Coalition to Support Quality Home Medical Equipment, Supplies and Services (Home Care Coalition) has been formed with a primary goal to focus on education and communications to its members, policy makers and the public. The participants in the Home Care Coalition believe that in meeting its goals, the Home Care Coalition will contribute to the well being of home care patients by advancing the concept that home care is a vital component of a cost effective health care delivery system. The Home Care Coalition is comprised of organizations whose members are touched by home care, ranging from consumer organizations to health professionals to provider organizations.

The Coalition was formed early in 1991 in response to the need to communicate the positive aspects of Home Medical Equipment, Supplies and Services (HME). There was and is a need to clearly communicate to Members of Congress and health policy makers that cuts in the Medicare Part B durable medical equipment benefit will adversely affect Medicare beneficiaries and the integrity of our health delivery system. By working collectively, with a unified, broad based group of organizations, the Coalition can communicate information that will improve the understanding of the appropriate and necessary role of the HME industry in home and health care.

2. Home Care is Vital and Fundamental

The Home Care Coalition shares the growing concern of patients, those within the health care community, and others over the direction and substance of United States national health care policy. The 1980's witnessed rapid advances in the development of health care technology and systems, as well as a rapidly growing elderly population. This created a home care alternative both for traditional acute needs as well as for newly identified needs in long term chronic care and preventive care. Home care is a leading example of desirable and patient preferred health care, and is a critical component of a system which provides appropriate and cost effective health care.

Congress must not overlook these positive and productive innovations in the health care delivery system for the United States. The Home Care Coalition urges Congress to recognize the importance of home care as a vital component of a cost effective health care delivery system. The Home Care Coalition strongly believes that home medical equipment supplies and services are a fundamental and integral component of any meaningful national health reform package.

The aging population will continue to grow, and medical technology advances will allow more and more patients, both the elderly and the disabled, chronic and acute, to lead more productive lives outside traditional institutional settings. With appropriate incentives, home care will be increasingly important in meeting the changing needs of the elderly via new and modified medical technology. And importantly, home care is both an acute and a long term care issue.

With appropriate management of the multiple types of services available to patients in their homes, there can be a cost effective alternative to long term care. The United States has an opportunity to demonstrate to the rest of the world that home care can be a humane and safe way to provide care to its citizens. The much talked about health care delivered in countries with a national health system does not include a home care delivery system, but our system can and must. We are already at a level of care that is remarkable for its organization. A patient can receive care in the home which is at the level of care usually reserved for institutional settings. And this is happening now. It is not a vision of the future. But Congress, health policy makers and the public must fully understand the scope of services patients can now receive in the home.

3. Home Care Contributes To Confidence and Productivity

Home medical equipment, supplies and services companies have achieved in the last ten years a level of performance which has helped beneficiaries and professionals gain confidence in the quality and availability of home care. HME enables patients to lead productive and fuller lives. High technology home care allows pregnant women to have fetal monitoring, and allows ventilator infants to be cared for at home.

The Home Medical Equipment industry has worked to become part of the total plan of care for patients in their homes. They have been coordinating with licensed and Medicare certified home health agencies which provide skilled services such as nursing and physical therapy in the home. The staff of the HME companies provide service not only to patients, but also provide support services to the nurses who coordinate care in the home. If a patient is receiving complex care in his or her home, there is ongoing communication between these two partners in care. A HME company and a home health agency have been working together for years in providing care to patients.

To clarify and demonstrate the range and importance of support services provided by HME companies, individual association organizations participating in the Home Care Coalition asked their members -- Medicare beneficiaries, hospital discharge planners, clinical practitioners -- to provide first hand examples from their daily worklife of how home medical equipment services brought value to their health care needs. Through these first hand reports, the Home Care Coalition demonstrates a model of home medical equipment services that is integral to the future of our United States home health care delivery capability.

4. Patients Prefer Home Care

A large and diverse population relies upon home care for a wide variety of medical reasons, and when given a choice, patients prefer to have their health care administered in the home. These are the results of a Consumer Research Study conducted recently by National Research, Inc.

The existing support services that are incorporated into the Medicare home medical equipment services benefit are absolutely essential to assure the timely availability of quality home care services. These support services range from timely delivery, set-up, and education for the beneficiary and family in their home; to technical, logistical and paperwork support for the hospital discharge planner and prescribing physician to achieve more cost effective delivery of care at home; to the supplier's inventory availability of the wide variety of products patients need in the home. A July 26, 1990 report by Lewin/ICF, "The Home Medical Equipment Industry: An Examination of the Industry's Expense Structure," describes these home care services and their value to the Medicare program.

5. Home Care Is Cost Effective

Allowing patients to recover and rehabilitate at home, and allowing disabled patients to reenter the mainstream with the support of home care equipment, supplies and services, is also cost effective.

A recently released report on cost-effectiveness of home medical equipment services underscores the need for our health care delivery system to include the availability of necessary HME services. In a study entitled "Economic Analysis Of Home Medical Equipment Services" (May 1991), Lewin/ICF analyzed three case examples: hip fracture, Amyotrophic Lateral Sclerosis (ALS) with pneumonia, and Chronic Obstructive Pulmonary Disease (COPD). Lewin/ICF concluded that savings of up to $2,330 per patient episode could be achieved, with annual savings potential of up to $575 million when home medical equipment is used following inpatient hospital treatment.

A May 1991 survey was conducted by the Gallup Organization to gather information on the status of chronic ventilator patients (patients dependent on a respirator to breathe), and to determine how and where care is rendered.

Gallup estimated that at any one time, there are approximately 11,400 chronic ventilator patients receiving care in United States hospitals. At an estimated cost of $789 per day, the cost to institutions is $9 million every day. Furthermore, because of current restrictions on access to home and non-institutional alternatives, once these patients are medically able to be transferred out of the hospital, it takes an average of 35 days to find a suitable placement. This equates to a cost of over $27,000 incurred by the patient for inpatient institutional care while he or she is waiting for post acute care services. According to the study, if there were appropriate coverage and reimbursement for home care and alternate site services, nearly 44 percent of those 11,400 chronic ventilator patients would be sent to non-institutional settings.

Patients being transferred to another facility spend days waiting for a space or waiting for the appropriate paperwork to be completed. For patients with a home to go to, the only waiting time is that which is required to develop a plan of care, to teach the patient's family or responsible person how to care for the patient, in some cases to teach the patient self-care, and to work with the the home health agency staff. The HME staff participate in the preparation of the plan to send the patient home, and also continue to work with all parties involved for the duration of care. (It must also be noted that some patients and families become independent in the necessary care and the HME staff may be the only health care professionals providing services to the patient in his or her home.)

6. Home Care Coalition Principles:

* Basic preventive care begins in the home.

* Basic health care delivery includes home care.

* The move to more care delivered outside of acute care hospitals will encourage high value home care services.

* Incentives must be provided for government, providers, and private insurers to pursue innovative health care delivery such as cost effective, high value home medical equipment, supplies and services.

* Managed care will encourage cost effective, high value home medical equipment, supplies and services.

* Reforms to increase availability in the small business insurance market will encourage recognition of cost-effective, high value home medical equipment, supplies and services.

* A competitive health care marketplace must include educated consumers that are empowered to choose home medical equipment, supplies and services.

IV. THE ADMINISTRATION'S FY 1993 BUDGET PROPOSAL FOR MEDICARE DME PAYMENT

HIDA opposes the Administration's proposed cuts for the Medicare durable medical equipment (DME) benefit. HIDA supports testimony of the Home Care Coalition to avoid legislation that will "adversely impact the ability of Medicare beneficiaries to receive timely and quality home medical equipment services."

The Administration's proposal relies on a General Accounting Office report that states its results are not projectable beyond the six suppliers studied. The report is limited to conclusions regarding six GAO selected suppliers. HCFA estimates there are 160,000 suppliers. Therefore, a sample of six is hardly appropriate for national policy making.

V. CONCLUSION

The focus of our near term efforts needs to be on the elimination of waste in our current health care delivery system. Pragmatic health policy makers are correct in believing that health care rationing is not a socially acceptable or equitable solution.

We are at a time of defining the ills of our current healthcare system, and attempting to define the remedy, or plan of treatment to correct these ills. The medical product distribution industry, through our trade association, is pleased to work with this Committee and other health policy makers to determine and shape the details of that solution.

Again, Mr. Chairman, we applaud you and the Committee's initiative in receiving testimony on these important issues involved in improving our nation's health care delivery system.

The Health Industry Distributors Association is privileged to work with the Committee and its staff in further developing legislation to address needed improvements in our nations health care delivery.

Statement of the Marine Retailers Association of America

Thank you, Mr. Chairman and distinguished Members. We at MRAA wish to thank you for your leadership in conducting this hearing on the status of the U.S. economy and for your willingness to listen to our concerns.

MRAA is the national trade association of about 3,500 small main street businesses which sell new and used recreational boats, equipment, and accessories and operate marinas. Our individual membership represents virtually every state in the country. In addition, about 120 local, state, and regional marine trades associations are affiliated with MRAA.

The recession, which began over two years ago, has had a damaging effect on our industry. Sales for much of the boating business is cyclical in nature, and we expect economic downturns as normal business activity. Our members have attempted to fight the effects of the recession by eliminating capital expansion plans, implementing wage freezes on workers, and carrying out aggressive cost cutting programs. Many of our members were also able to keep their businesses operating by headcount reductions. This natural downsizing occurs in our industry during recessionary times. Historically, we can expect to see sales declines of up to forty per cent. And, in fact, sales revenues and unit volume had declined about forty per cent in 1990 from record sales levels in 1988.

However, beginning in January last year, we have had to contend with a totally unexpected variable imposed on us by the Federal government, a 10 per cent Luxury Excise Tax on recreational boats exceeding $100,000. This tax has been the "straw that broke the camel's back" for our industry. We believe it is a regressive tax imposed without due Congressional process and without proper analysis and study. Imposed "in the heat" of a very complex budget agreement.

Since this tax has come on the scene, we have had significant numbers of business closings and layoffs that far exceed normal recessionary hard times. The timing of the Luxury Tax could not have been worse. With the industry already in a deep economic downturn, sales revenues of all boats have since plummeted even further, but sales of boats subject to the tax or those boats exceeding $100,000 are nil. MRAA, through the Advisory Council of Marine Associations, has been conducting an extensive survey of recreational boat dealers. The survey has been measuring unemployment and sales revenues and sales unit volumes for boats which cost under $100,000 and for boats whose cost exceeds $100,000. The results for 1991 indicate that sales of boats under the $100,000 threshold for the Luxury Tax are down about 28 per cent from 1990, and sales of boats over the $100,000 threshold are down over 71 per cent.

What is even more bothersome to our members is that with what few sales have been made in the over $100,000 category, either the dealer or the manufacturer has had to absorb the Luxury Tax. The sales simply would not have been made, if the consumer had to pay the tax. Profit margins have been eroded because of higher interest charges (due to boats being in inventory longer than normal) and the economic effects of recessionary times. With the added burden of dealers having to pay the Luxury Tax to sell boats, our members have been losing money on the boats sold.

These dire sales figures have resulted in significant downsizing of employment at marine dealerships in 1991. These same dealers reported a 37 per cent reduction in jobs in 1991 over the already reduced employment of 1990. We conservatively estimate over 20,000 of our employees have lost their jobs since the Luxury Tax was implemented.

In addition, many businesses have closed operations. At the end of 1990, there were approximately 17,700 recreational boat businesses in our country. Based on several mailings we have made in 1991, we have had to purge our mailing list of over 4,000 businesses. These firms have ceased operations. The sad part of this is that I expect many more dealers may be closing their businesses in the next several months.

What originally was a "Tax the Rich" scheme by Congress has resulted in a catastrophic job loss issue affecting tens of thousands of blue collar workers. Many of these unemployed workers remain unemployed and are having extreme difficulties obtaining employment elsewhere. This is because of the difficulty of getting jobs during the recession, but it is also because of the specialized nature of many of the jobs in our industry.

Typically, one of our blue collar employees has been with the dealership since high school graduation and is trying to raise a family on less than $25,000 per year. They do not have college educations, but a few have been to a trade school. Most have learned their craft while training "in house." Our employees become specialized in fiberglass repair, mechanics, rigging, and clerical support.

I hear stories every day about layoffs of longstanding, hard working employees. I hear stories every day about prospective customers who have decided not to purchase boats affected by the tax. We even hear stories about prospective customers who have decided not to purchase boats under $100,000 because they think the tax applies to these boats too. Many customers are telling us that they do not like being singled out and will not buy or trade up because of the Luxury Tax.

We believe very strongly that the luxury tax on recreational boats has had a significant material impact on the economic well-being of our industry and that its immediate repeal is necessary. Congress sometimes makes mistakes. We ask that you reconsider the luxury tax and include its repeal in a "Tax Relief" bill Congress is now considering.

The members of MRAA are opposed to the tax because:

- We believe our industry has been wrongly singled out in an unfair attempt to balance the Federal budget deficit when the recreational boating industry has been a positive contributor to the American economy by being a net exporter and by providing a growing tax base,
- The Tax is only raising a mere fraction of the anticipated Federal tax revenues,
- The Tax is causing massive unemployment of blue collar workers,
- The Tax is causing massive business closings of boat dealers and boat manufacturers,
- The Tax is causing massive reductions in collections of state and local sales taxes,
- The Tax is causing significant reductions in corporate and individual state and Federal taxes, and
- The Tax is causing significant increases in the costs of unemployment benefits to displaced workers.

Our industry needs your help to survive. We ask that you repeal this tax now.

We again thank you, Mr. Chairman for holding this hearing and for listening to our concerns.

ACMA

ADVISORY COUNCIL OF MARINE ASSOCIATIONS

Providing Support for the Marine Industry through M.R.A.A.

COMPARISON OF SALES VOLUME, UNIT VOLUME
AND EMPLOYMENT 1991 vs. 1990

Impact On Sales Of Vessels Valued OVER $100,000.00

Reporting Dealers		Sales Volumes By Units Sold				Sales Volumes Dollar Amount Sold				Employment Overall Impact			
State	#	1990	1991	Change	% Change	1990	1991	Dollar Difference	% Change	1990	1991	Change	% Change
CA	21	192	46	-146	-76.04%	$40,096,923.00	$7,653,964.00	($32,442,959.00)	-80.91%	471	246	-225	-47.77%
CT	1	14	3	-11	-78.57%	$3,480,000.00	$390,000.00	($3,090,000.00)	-88.79%	12	7	-5	-41.67%
FL	18	141	62	-79	-56.03%	$26,961,461.00	$6,799,993.00	($20,161,468.00)	-74.78%	354	282	-72	-20.34%
MA	11	72	31	-41	-56.94%	$12,781,779.00	$5,417,268.00	($7,364,511.00)	-57.62%	196	120	-76	-38.78%
MD	17	277	96	-181	-65.34%	$46,079,864.00	$20,052,392.00	($26,027,472.00)	-56.48%	735	393	-342	-46.53%
ME	2	18	6	-12	-66.67%	$3,686,000.00	$815,000.00	($2,871,000.00)	-77.89%	55	42	-13	-23.64%
MI	18	226	100	-126	-55.75%	$43,880,213.00	$16,049,630.00	($27,830,583.00)	-63.42%	574	404	-170	-29.62%
NC	3	12	2	-10	-83.33%	$1,590,000.00	$308,000.00	($1,282,000.00)	-80.63%	26	18	-8	-30.77%
NH	4	9	0	-9	-100.00%	$1,745,803.00	$0.00	($1,745,803.00)	-100.00%	102	70	-32	-31.37%
NJ	5	46	14	-32	-69.57%	$8,478,485.00	$1,749,819.00	($6,728,666.00)	-79.36%	159	110	-49	-30.82%
NV	1	3	0	-3	-100.00%	$465,000.00	$0.00	($465,000.00)	-100.00%	18	12	-6	-33.33%
NY	4	74	11	-63	-85.14%	$17,190,000.00	$1,747,000.00	($15,451,000.00)	-89.84%	110	71	-39	-35.45%
OH	1	8	5	-3	-37.50%	$1,151,164.00	$594,573.00	($556,591.00)	-48.35%	23	10	-5	-21.74%
OR	2	43	9	-34	-79.07%	$11,027,000.00	$2,215,000.00	($8,812,000.00)	-79.91%	51	34	-17	-33.33%
PA	1	3	0	-3	-100.00%	$390,102.00	$0.00	($390,182.00)	-100.00%	8	6	-2	-25.00%
RI	3	13	3	-10	-76.92%	$3,300,000.00	$2,800,000.00	($500,000.00)	-86.27%	170	88	-82	-48.24%
TX	1	9	3	-6	-66.67%	$1,705,000.00	$417,000.00	($1,288,000.00)	-75.54%	8	6	-1	-16.67%
VA	1	8	1	-7	-87.50%	$1,300,000.00	$155,000.00	($1,145,000.00)	-88.08%	11	8	-5	-45.45%
WA	5	75	28	-47	-62.67%	$19,375,562.00	$6,065,000.00	($13,310,562.00)	-68.70%	82	52	-30	-36.59%
WI	2	11	2	-9	-81.82%	$2,217,446.00	$221,465.00	($1,995,981.00)	-90.01%	25	20	-5	-20.00%
TOTALS	121	1254	422	-832	-66.35%	$251,915,882.00	$73,451,104.00	($178,464,778.00)	-70.84%	3188	2004	-1184	-37.14%

ACMA

Advisory Council of Marine Associations

Providing Support for the Marine Industry through M.R.A.A.

COMPARISON OF SALES VOLUME, UNIT VOLUME
AND EMPLOYMENT 1991 vs. 1990

Impact on Sales of Vessels Valued UNDER $100,000.00

Reporting Dealers		Sales Volumes Total Units Sold				Sales Volumes Dollar Amount Sold				Employment Overall Impact			
State	#	1990	1991	Change	% Change	1990	1991	Dollar Difference	% Chnge	1990	1991	Change	% Change
CA	12	1602	598	-1004	-62.67%	$25,542,471.00	$15,802,394.00	($9,740,077.00)	-38.13%	284	139	-145	-51.06%
CT	1	88	55	-33	-37.50%	$4,100,000.00	$2,800,000.00	($1,300,000.00)	-31.71%	18	14	-4	-22.22%
FL	8	319	287	-32	-10.03%	$4,607,610.00	$3,732,699.00	($874,911.00)	-18.99%	167	117	-50	-29.94%
IN	1	24	17	-7	-29.17%	$419,000.00	$306,000.00	($113,000.00)	-26.97%	12	7	-5	-41.67%
KY	1	76	70	-6	-7.89%	$2,254,866.00	$1,639,189.00	($615,677.00)	-27.30%	16	13	-3	-18.75%
MA	17	1398	952	-446	-31.90%	$21,775,696.00	$15,953,206.00	($5,822,490.00)	-26.74%	210	150	-60	-28.57%
MD	3	20	17	-3	-15.00%	$1,220,512.00	$992,229.00	($228,283.00)	-18.70%	23	17	-6	-26.09%
ME	2	65	45	-20	-30.77%	$2,629,000.00	$1,408,000.00	($1,221,000.00)	-46.44%	29	16	-13	-22.00%
MI	22	3462	2370	-1092	-33.48%	$58,274,564.00	$44,528,233.00	($13,746,336.00)	-23.59%	831	619	-212	-25.51%
NC	3	204	134	-70	-34.31%	$3,939,081.00	$2,615,651.00	($1,323,430.00)	-33.60%	76	52	-24	-31.58%
ND	2	197	173	-24	-12.18%	$5,141,151.00	$3,532,899.00	($1,608,252.00)	-31.28%	141	90	-51	-36.17%
NH	3	389	306	-83	-21.34%	$5,645,483.00	$4,666,574.00	($978,909.00)	-17.34%	97	80	-17	-17.53%
NJ	6	362	212	-150	-41.44%	$8,394,713.00	$4,368,660.00	($4,026,053.00)	-47.96%	54	44	-10	-18.52%
NV	1	213	183	-30	-14.00%	$3,305,551.00	$2,760,518.00	($545,033.00)	-16.49%	19	15	-4	-21.05%
NY	6	234	109	-45	-19.23%	$5,144,615.00	$4,151,959.00	($992,655.00)	-19.30%	89	74	-15	-16.05%
OH	2	230	211	-19	-8.26%	$5,195,489.00	$3,919,410.00	($1,276,079.00)	-24.56%	39	30	-9	-23.08%
OR	2	189	132	-57	-30.16%	$6,912,000.00	$6,217,000.00	($695,000.00)	-10.05%	54	46	-8	-14.81%
PA	1	29	27	-2	-6.90%	$742,964.00	$482,370.00	($260,594.00)	-35.07%	10	8	-4	-40.00%
RI	1	6	3	-3	-50.00%	$180,000.00	$70,000.00	($110,000.00)	-61.11%	4	3	-1	-25.00%
TX	2	46	27	-19	-41.30%	$1,832,292.00	$1,168,367.00	($663,925.00)	-36.23%	13	11	-2	-15.38%
VA	1	250	183	-67	-26.80%	$5,340,000.00	$3,200,000.00	($2,140,000.00)	-40.07%	63	42	-21	-33.33%
WA	2	144	205	61	42.36%	$2,995,694.00	$4,104,748.00	$1,109,054.00	37.02%	46	44	-2	-4.35%
WI	2	40	16	-24	-60.00%	$1,056,974.00	$423,398.00	($633,576.00)	-59.94%	15	10	-5	-33.33%
TOTALS	101	9397	6222	-3175	-33.82%	$176,649,726.00	$128,843,504.00	($47,806,226.00)	-27.66%	2310	1639	-671	-29.65%

Statement of the National Business Travel Association

The association appreciates the opportunity to present its views on the matter of national economic recovery. We have a vital stake in this debate. Our membership consists of many Fortune 500 company travel managers and others from smaller companies, as well as transportation and service providers who rely on corporate travel. A recent airline industry study indicates that 48% of the seats in domestic air travel are occupied by business travelers. They are the primary source of revenue for the airlines since business travelers generally pay higher fares. As a result of the federal ticket taxes, they are also the largest source of revenue for the Aviation Trust Fund. The ripple effect of business travel is tremendous through the airline, hotel, car rental and food industries and is an accurate barometer of the vigor of the nation's economic activity. When we do well, they do well. The reverse is also true, unfortunately.

Our members and affiliates usually account for about $30 billion annually in purchases of airline tickets, car rentals, airport limousines, meals and hotel or motel rooms. We have not been spending at this rate recently because of the recession and the constriction of business activity, budget cutbacks and a reduction in the frequency of corporate travel. When the economy is reinvigorated, business activity will rise, and with it the corporate travel on which so many people rely. The effect of that will be felt almost immediately throughout the economy, as there are more airline seats occupied, car rentals taken, and more reservations made for hotel rooms and food establishments.

A PROBLEM ABOUT THE FUTURE

We believe that the nation is truly at a major crossroad, and the response of Congress will have much to do with determining what kind of future we will have. The important thing to realize is that there is no magic wand that can be waved to achieve instant recovery. One of our central concerns must be to be sure that decision makers avoid doing the wrong thing again and some past mistakes must be undone.

The recession is not a natural disaster. It is man made. It is the result of flawed policies. The economic dilemma that we find ourselves in now is the consequence of anti-growth policies that have been adopted over time. The mistakes which flow from the 1986 Tax Reform Act, the 1990 budget summit and record tax increases have all come together to create this recession and sap the economic vigor of the country. "The 1986 Tax Reform Act greatly reduced the return to businesses capital investment. The economy has since lost approximately $300 billion in growth-creating investments in the private sector . . . by raising the cost of capital, government policy has discouraged the formation of new businesses by making investment too costly and less rewarding," a major business organization points out.

The problem is a deterioration in long-term growth brought about by mistaken fiscal policies. An economist's study describes it this way. ". . . the current recession is no mystery. For nearly six months last year (1990), politicians debated which taxes they should raise. This created uncertainty in the financial markets, lowered consumer confidence and undermined investors' faith in the future. The prolonged debate resulted in agreeing to saddle workers, consumers and businesses with the largest single-year tax increase in America's history. When combined with the enactment of costly new regulatory legislation such as the Clean Air Act and [others], this tax increase was a body blow to an already fragile economy."

That realization has penetrated the public consciousness, and there is an understandable pessimism that the right thing will be done about it. That underlies the recession and makes recovery more difficult. Economists and national decision-makers have been struck by the fact that this recession unlike others is characterized not only by a remarkable level of misery, but even more, a malaise that flows from a public lack of confidence.

The national mood was aptly described recently by Federal Reserve Chairman Alan Greenspan when he told Congress: "There is a deep rooted concern out there which I must say to you I have not seen in my lifetime . . . It is very hard to grasp the depths of the concerns unless you look at it as a problem about the future."

The economy may by itself achieve a modest recovery but long-term growth will not come about unless decisive and correct action is taken. The Congressional Budget Office confirmed this in testimony to the committee, predicting that we would begin to come out of the recession this spring but that recovery will be weak. Congress has a unique opportunity to refashion the future and rebuild public confidence through a sound long-term growth policy that emphasizes investment incentives, savings, capital formation and a proper dose of restraint in spending. It is a problem of the future—today.

SHORT-TERM VS. LONG-TERM

We urge this committee and the Congress to take the long view and to forget the notion of "jump starting" the economy. There is very little to be gained by jump starting a car with burned out battery cells when it really needs a new battery, an engine overhaul, a new driveline, and then to be driven down a different road in order to get where it should be. Or maybe we need a whole new vehicle.

The committee and the Congress should not yield to short-term politically appealing measures in this election year but do what is good for the country in the long run. Proposals have been put forward, for example, to enact a $300 rebate to an individual or a family with the rationale that it will encourage consumption. In fact, such a measure will be of virtually no use. It will not be instrumental in bringing us out of the recession and will only make the national deficit problem worse. It is a political response, not an economic response.

Economist John Makin points out that foal measures to stimulate consumption at this stage will likely be counterproductive. "A tax rebate or one-time-only measure directed at temporary demand stimulus with no implications for encouraging investment for growth of aggregate supply would be viewed as a continuation of the ad hoc stop-gap approach to economic policy that leaves unaddressed the economy's long-run problems," he stated.

In the current debate, the issues will revolve around deliberations of what to do with defense savings or the peace dividend, short-term measures to cope with the recession, and how to create economic growth. We urge decision-makers to adopt a long-term, pro-growth package as the key to a future healthy sound America.

The benchmark of such an approach should be the degree to which it serves to rejuvenate the economy, stimulate business activity, create jobs and provide investment incentives, savings and capital formation that lead to long-term productivity.

In that context, we offer our suggestions to revive the economy, corporate activity, and, in the process, business travel as well. No one measure by itself will cure our current economic malaise, but as a series of reinforcing initiatives, they can be instrumental in putting the economy on solid footing again—on into the future.

ECONOMIC GROWTH AGENDA

- Initiatives to Encourage Investment
- Modified Capital Gains Tax
- Capital Formation and Savings Incentives
- Roll back Air Passenger and Cargo Taxes
- Repeal Luxury Tax on Aircraft Sales
- Eliminate Double Corporate Taxation

INVESTMENT INCENTIVES

Investment is the key to America's recovery and future. It is critical that Congress recognize this and reestablish capital incentives, especially the investment tax credit. In order for it to be fully functional, the interactive mechanism of the alternative minimum tax must be changed as well.

The AMT now negates new or existing incentives which could encourage investment in productive assets. The remedy is allow the investment tax credit to offset any alternative minimum tax liability as well as regular tax liability.

Beyond that, current depreciation rules should be reexamined as they apply to investment in facilities and equipment. Accelerated depreciation could be a particularly valuable weapons in stimulating growth.

Today's tax code discourages productive investment by the way that depreciation is treated. Inflation makes the problem even worse. The ideal remedy under a normal vigorous economy would be to allow businesses to immediately deduct from taxable earnings the full value of a capital purchase. We recognize, however, that such a move must be considered in relation to the total effect of all investment incentives. The revenue loss to the Treasury would be significant. We believe that Congress should consider accelerated depreciation to the degree that the revenue impact is acceptable in any pro-growth package. An effective interim step would be to give businesses a greater incentive to invest at this time by indexing for inflation the value of depreciation allowed each year.

Airline Capital Needs

The reintroduction of the investment tax credit and a change in the alternative minimum tax would have an appreciable affect on the airlines. The industry has been flying through heavy economic turbulence, losing $3.9 billion in 1990 and approximately $1.8 billion last year. Ironically, at a time when they are experiencing

such heavy losses, some airlines have been forced to borrow more money to pay the alternative minimum tax.

To a large extent, an improvement of the airline industry will come about as the overall economy recovers. That in turn depends on the success of changes in tax policy which provide for enhanced investment incentives and the degree to which they are reflected in revitalization of business activity at all levels. Immediately, however, Congress needs to focus on the specific measures that will help the industry regain its economic vigor. Investment incentives, such as the ITC, are needed as well for airlines to meet their long-term need for capital to purchase new aircraft.

The airlines have proposed legislative changes "to create capital formation incentives which will restore the industry's health, stimulate growth, and encourage new investments." We urge the Congress to give these suggestions careful consideration. The recovery of the industry and the availability of capital to meet long-term growth needs is vitally important not only to the air carriers, but to aircraft manufacturers, businesses which utilize airlines for shipping, air travelers, and communities throughout the nation.

Business travelers and corporate travel managers have a special stake in this issue. First of all, corporations need a pervasive air transportation system to move goods and people to conduct business. Secondly, the airlines have identified a need for $150 billion worth of aircraft in the future. There are only two sources that airlines have to get enough money—investment mechanisms, or the airline passenger. The airlines cannot buy the planes they need if appropriate investment tools such as the ITC are not available, and they cannot continually raise fares enough to develop the necessary capital.

Already, the point of saturation has been reached, and continued upward pressure on the price of airline tickets and cargo will be counterproductive. The airlines have recognized that they have severe limitations in increasing ticket prices because of the elasticity of the market. More importantly, they have recognized that the cost of air travel has escalated dramatically with new federally mandated taxes and fees on passengers, which will hit fully this summer, and serve as a further suppressant to recovery of the industry. The airlines and the people who pay the tax—business travelers primarily—are asking that some of these taxes be rolled back.

Given this set of circumstances, the airlines cannot get all they need out of the passengers alone to meet future capital needs, and it is imperative that the tax mechanism provide some investment latitude.

MODIFIED CAPITAL GAINS TAX

The capital gains tax should be reestablished as a means of incentifying investment. The 1986 Tax Reform Act raised the tax rate on capital gains by 40% as Congress moved away from a pro-investment policy. Legislation has been introduced to reduce the capital gains tax to 15% for all assets. We believe that this measure would be a valuable component in a package to revitalize the economy and create long-term growth. Allen Sinai, chief economist for the Boston Company has projected that a reduction in the capital gains tax to 15% would raise the GNP by 0.4% annually through 1995, create 2.5 million new jobs and generate an additional $30 billion to $40 billion of new tax revenues over the next five years.

Another economist has estimated that the after tax cost of capital for American business would decline by more than 4% a year as a result of this measure. The overall effect would be to remove the bias against income from capital that is reflected in our tax code today. An ancillary effect would be an enhancement of the value of RTC real estate holdings by 6% to 12%, a significant near-term gain.

Other countries such as Germany and Japan have already reduced the level of taxation on income from capital to assure a steady growth of capital that promotes growth in labor productivity and real wages. They understand that such a tax is counterproductive because it does not help them raise revenue or capital to spur investment. America needs to reach this same realization.

The existing 28% tax on capital gains is imposed on the difference in nominal value between the purchase price and the sale price of an asset. Consequently, it discourages productive investments. We believe it is time to put an end to this shortsighted practice.

There are those who advocate total elimination of the capital gains tax as the best pro-growth policy. At this time we believe that reducing it to 15% and indexing for inflation is a good interim step. This will provide a real life test on which a further step could be based later if warranted. In order to encourage investment and not just short-term speculation, we advocate that this credit be eligible for assets held at least three years.

CAPITAL FORMATION AND SAVINGS

One of the root problems underlying our economic dilemma is a lack of capital to fuel investment. America has been consuming and going deeper into debt rather than saving. An essential means of raising productivity and investment is to develop savings to provide capital. Without that step, the hope of a strong and full economic recovery is illusory.

A leading political figure said it best: "Capitalism without capital is nothing but an abstract ideal . . . You cannot improve the standard of living of people without increasing the amount of capital invested per capita."

To some extent, the country is now paying the price for excessive debt and consumption. Experts point out that our earlier long expansion came at the expense of a sharp decline in savings and an enormous increase in the total debt of governments, households and businesses.

It is no coincidence that the nation's slide into a recession has been accompanied by an unprecedented decline in national savings. Total national savings averaged more than 8% of net national product prior to the 1980's. It then dropped to 4.9% and moved downward to 2.9% by 1990.

Unless we cure this problem, we cannot achieve significant long-term growth and productivity. The pro-investment measures we've proposed will help, but something must be done as well to incentify personal savings. One step would be for Congress to restore the full benefits of allowing people to make deposits to IRA and 401(k) accounts.

The course of tax treatment of IRA's clearly shows what mistaken policies can do. The IRA was specifically created to encourage savings. The IRA incentive worked and then it was cut back.

We believe that restoring full deductibility of individual retirement accounts for everyone will, in fact, create a considerable amount of new savings. In a recent television appearance, Senator Lloyd Bentsen forecast 40% more savings with a full IRA. That's significant. Congress may choose to free up the use of IRAs to relieve pressure on individuals to buy homes, meet education expenses or other purposes. In any event, the savings generated by a fully functional IRA would be very beneficial in helping form the capital pool that America needs for long-term prosperity.

AIR PASSENGER AND SHIPPER TAXES

While the measures we've suggested will take awhile to take effect, there is one that can have an almost immediate impact. That is to roll back the recent federal tax increase on airline passengers from 10% to 8% and the cargo tax from 6¼% to 5% where they were before. This would stimulate air travel and encourage business shipping again. It would get the "ripple" effect going that would help the airlines car rentals, hotels, food establishments, as well as businesses and communities throughout the nation.

Most importantly, this step could take effect by summer when taxes are expected to go up again, as much as $12 a roundtrip ticket as a result of Congressional action last year. Congress authorized local airports to levy this much in "passenger facility charges." As a result of this added charge, the total taxes on even a discount coach ticket for a transcontinental roundtrip with an intermediate step, would be at least $80 and will, of course, usually be higher. This will add a significant cost item to corporate budgets and it will serve as a further disincentive to travel.

The imposition of PFC's comes on top of the 1990 increase of passenger taxes from 8% to 10% and the cargo tax from 5% to 6¼%. Clearly, the level of federally imposed or authorized taxes and fees on airline passengers has reached an intolerable level. This provides a disincentive which will further dampen the recovery of air travel. By reducing the federal passenger and cargo tax back to where they were, Congress can at least help offset some of the impact of the new airport PFC's that will hit passengers this summer.

The airlines and we agree that the taxes need to be reduced. An airline analyst projects that a reduction from 10% to 8% on the domestic ticket tax could stimulate a 1.4% increase in traffic that would mean an additional 6.5 million passengers. Translated into impact on the airlines, the analyst says this could increase profits to the industry about $300 million, and involve an additional 7,500 jobs.

REPEAL OF LUXURY TAX ON AIRCRAFT SALES

The luxury tax was a result of the budget summit agreement in 1990. It is a classic example of distorted tax policy. It was forecast that the tax would bring in $1.5 billion between 1991-1995. The estimate for 1991 alone was for more than $20 million. It didn't happen.

The projection for private aircraft sales was wildly off. The IRS reports that it collected only $53,000 where it had expected to take in $6 million from aircraft sales.

Beyond that, the tax has constricted sales and cost jobs in every business that it applies to, a result that Congress never thought would happen. In July of 1990, a Joint Economic Committee Republican study showed that the luxury tax will end up eliminating 9400 jobs in the aircraft, boat and jewelry industries and will actually end up losing revenue.

Senate majority leader George Mitchell perhaps assessed the tax best in a floor speech when he said, "Whatever may have been the theoretical reason for advancing it, it has proven in its implementation not to have worked as intended."

The tax has seriously hurt the corporate and private aircraft manufacturing business. In 1991, manufacturers shipped fewer airplanes to dealers and customers than in any year since World War II, reflecting, in great measure, the impact of the excise tax.

A Price Waterhouse projection indicates that between 33 and 100 personal use aircraft are affected annually by the tax, and that sales would be reduced as much as 50%. It is estimated that the tax will reduce full-time employment in the aircraft sector by as many as 270 more workers in 1992, and as many as 200 annually in the next two years, with more lost in the parts manufacturing sector due to the ripple effect. Beechcraft has reported that one job was lost for every $64 raised in taxes. The toll has been the loss of 53 aircraft sales for that company and 125 jobs.

Clearly, this is a tax that met no one's expectations. It is counterproductive and needs to be repealed.

ELIMINATE DOUBLE CORPORATE TAXATION

Tax experts have talked for some time about integrating the corporate and individual tax systems. It's timely to do this now in any economic recovery package. Just this month, the Treasury Department issued a study which concluded that this move is "desirable."

The study estimates that integration would increase the capital stock in the corporate sector by $125 billion to $500 billion and decrease debt-to-asset ratio from 1% to 7%. Further, it would translate into a gain for the overall economy of as much as $25 billion annually. These are certainly results that are worth getting into the mainstream right away. Almost all of the United States' major trading partners have already adopted integrated tax systems and we need to get on equal footing.

We believe that the Treasury study is on target with its findings. Integration will produce a substantial economic benefit by reducing the costs of certain distortions which are inherent in the two-tier tax system. The current system does encourage investment in non-corporate rather than incorporate businesses, encourages financing corporate investments with debt rather than equity and provides an incentive to retain earnings or to structure distributions to avoid the double tax.

Non-tax benefits would flow from integration because it encourages the adoption of capital structures less vulnerable to instability in times of economic downturn, the study points out.

The Treasury study sets forth options which warrant careful consideration. Under the "dividend exclusion" approach, shareholders who receive corporate dividends would exclude those payments from gross income. In this scenario, corporations would continue to pay at the 34% rate. This approach could be implemented relatively easily and with little change in the current law.

The Treasury, however, suggests that a greater change be considered as well, known as a comprehensive business income tax system (CBIT). Under this approach, corporate dividends and interest would not be taxed by investors when received, but the income of all business entities would be taxed at the entity level at a 31% rate. A corporation would not be allowed to deduct either dividend or interest payments to shareholders.

The value of the CBIT approach, according to the Treasury study, is that it would equalize the treatment of debt and equity, tax corporate and non-corporate entities alike and reduce tax distortions between retained and distributed earnings.

We are aware that these options must be considered in relation to their revenue impact within the entire range of a recovery package. In view of the beneficial impact of the dividend exclusion approach in encouraging and rewarding investment, it would be feasible to at least consider a phased in version. Then, as the economic results of the recovery package begin to flow, Congress could give further consideration to adoption of the CBIT system.

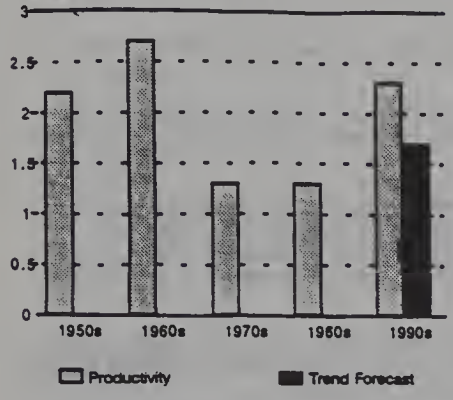
FEDERAL SPENDING

Some businessmen and economists believe that a reduction in the federal budget is the single most important step that can be taken to assure revitalization and long-term growth of the economy. Certainly, the growth policies we have advocated would be thwarted if Congress continues to spend without regard to the effect of that action. The last link in the chain of recovery must be reasonable budget restraint and reduction. Deep cuts in defense spending alone won't solve the problem.

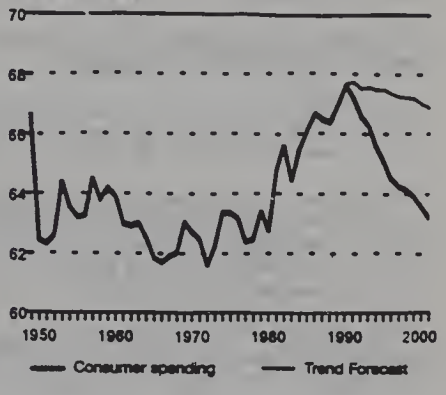
Current-projections show that in the fiscal 1992 budget, federal spending will absorb about 25% of America's output. The result is that the government is taking an unprecedented level of resources out of the productive sector of the economy.

We recognize the short-term problems involved with a complete spending freeze at this time. Nonetheless, we do believe that it is reasonable to adopt a policy of capping federal spending on entitlement programs at an annual rate of 4% growth.

The 1980s Saw Weak Productivity Growth



As We Consumed More and Invested Less



We Need More Saving to Finance Growth
Net Saving and Investment
(Percents of GNP)

	Net Personal Saving	Net Business Saving	State and Local Surplus or Deficit	Federal Surplus or Deficit	Net National Saving *	Capital Outflow (–) or Inflow (+) from Abroad	Net Domestic Investment **
1950–54	4.7	2.6	–0.2	0.1	7.3	0.1	7.6
1955–59	4.7	2.9	–0.3	0.1	7.5	–0.4	7.3
1960–64	4.4	3.3	0.1	–0.3	7.5	–0.8	6.7
1965–69	4.8	3.7	0.0	–0.3	8.2	–0.4	7.8
1970–74	6.0	2.2	0.6	–1.2	7.6	–0.3	7.5
1975–79	5.2	2.7	1.0	–2.3	6.6	–0.2	6.5
1980–84	5.3	2.2	1.3	–3.7	5.0	–0.3	4.7
1985–89	3.5	1.0	1.2	–3.8	2.0	1.8	3.8
1990–94	3.8	1.5	0.9	–3.0	3.0	0.3	3.3
1995–99	3.8	1.7	0.8	–0.3	6.0	0.4	6.4
				TREND			
1990–94	3.5	0.8	0.9	–3.1	2.1	0.4	2.5
1995–99	3.7	0.6	1.1	–2.1	3.2	0.5	3.7

* Net national saving is the sum of columns 1 through 4.
** A statistical discrepancy is omitted from this table.

Source: David Wyss, DRI/McGraw-Hill

ALAN CRANSTON
CALIFORNIA

United States Senate

WASHINGTON, DC 20510-0501

January 17, 1992

Mr. Norman R. Sherlock
1650 King Street, Suite 301
Alexandria, Virginia 22314

Dear Mr. Sherlock,

Many thanks for contacting me regarding aviation taxes and the Aviation Trust Fund. I apologize for the delay in responding.

I too, believe that all aviation taxes should go directly into the aviation Trust Fund and that the Trust Fund should be spent -- as originally intended -- to improve aviation safety and increase capacity for the '90s and beyond.

As you know, the President proposed and the Congress approved increases in aviation user taxes as part of the reauthorization process last year. Those increased taxes went into effect in December on domestic airline tickets, freight fees, jet fuel and aviation gasoline. In addition, airports are now empowered to assess a "passenger facility charge" to raise funds for local projects.

I worked hard during the conference on the legislation to insure that the greatest possible portion of the user fees went to the Trust Fund where it could be used for aviation safety and capacity enhancement as the taxes were originally intended.

Still, billions of dollars collected from those who use the nation's airways are being held in a trust fund account in an effort to disguise the size of our annual deficit. The Airport and Airway Trust Fund currently carries a $7.5 billion balance. While the taxes already paid by the traveling public sit idle in the trust fund, our airports struggle to handle -- safely and effectively -- the ever-increasing number of air passengers. It's unfair to ask taxpayers to contribute to the fund when it's not being spent for its intended purpose.

I support efforts and have cosponsored legislation which would take the aviation trust fund off-budget. This would enable us to spend down the trust fund to improve safety and increase the system's capacity.

I appreciate your thoughtfulness in taking the time to share your interest with me. I will most certainly keep your ideas in mind as we come to grips in Congress with the many problems confronting the traveling public.

With best wishes,

Sincerely,

Alan Cranston

Alan Cranston

NCSSSA *National Conference of State Social Security Administrators*

February 11, 1992

Mr. Wayne Hosier
United States Senate
Committee on Finance
Washington, D. C. 20510

Dear Mr. Hosier:

It has come to the attention of the National Conference of State Social Security Administrators that President Bush's budget recommendation for the Fiscal Year 1993 includes a proposal to extend Medicare coverage to all state and local government employees.

As Co-chairman of the NCSSSA's Legislative Committee, I offer this written statement to be filed for the printed record of the Senate Finance Committee hearings on February, 12, 13, 18 and 19, 1992, concerning the U. S. Economy and Proposals to Provide Middle-Class Tax Relief and Economic Growth.

I specifically wish to address the mandatory Medicare proposal. Under current law, a phase-in approach is in effect allowing state and local governments to gradually absorb the added cost of Medicare. State and local government employees hired prior to April 1, 1986, are excluded from Medicare coverage. This process allows the normal employee turnover to decrease the number of employees in state and local governments who are not covered by Medicare. The Social Security Administration has estimated that one-half of the 1986 number of non-covered employees will have Medicare coverage by next year, if the phase-in approach is allowed to continue.

The extra cost of adding Medicare coverage for all state and local government employees on July 1, 1992, as proposed in the Bush administration's budget recommendation, would be devastating. The shifting of federal deficits to state and local governments in the 1980s has been followed by the deep recession of the 1990s.

State and local government budgets have already been pared to the point of threatening basic services and layoffs, cutbacks and furloughs of public workers have become the rule, rather than the exception. The additional millions that would be drained from state and local coffers by mandatory medicare is unconscionable. In addition to the siphoning of money that would be better spent in our nation's states and communities, mandatory Medicare would also take another piece from the salaries of a group of American workers who already rank near the bottom of the nation's wage scale.

The phase-in approach to Medicare is an efficient and economical method to provide coverage for state and local government employees. It is as equitable as possible for all concerned and, most importantly, the phase-in approach is working.

The NCSSSA urges the members of the Senate Finance Committee to side with fairness and efficiency and defeat this latest proposal for mandatory medicare.

Sincerely,

Patrick L. Doyle

Patrick L. Doyle, Co-Chairman
Legislative Committee, NCSSSA

STATEMENT OF THE NATIONAL INDIAN POLICY CENTER

Investment and Employment Tax Credits For American Indian Reservation and Trust Lands: An Analysis of Benefits and Costs

William L. Stringer

"In Indian country, developing reservation economies is viewed as the path to developing self-sufficiency, decreasing the dependency that is so destructive of reservation societies, and improving the overall quality of life on reservation, thereby preserving Indian societies and cultures."[1]

Purpose: For a number of years, Congress and public interest groups have considered the provision of a number of tax incentives targeted to Indian reservations and reservation enterprises. It is the view of many experts, political leaders and tribal leaders that such tax incentives can attract industry and capital, expand existing industry, and make reservation enterprises vital and permanent employers within Indian country. Indian advocates in the Congress and tribal representatives have repeatedly attempted to secure such provisions. Congress has responded with numerous Federal payment and support programs but has failed to provide the type of incentive which would promote self-sufficient enterprise growth.

The 1992 Economic Stimulus Initiative, currently under consideration by the US Congress, provides a unique and unprecedented opportunity to enact an Indian Investment Tax Credit and Indian Employment Tax Credit. Such a program of investment and employment incentives is an essential ingredient needed to solve the chronic economic problems of Reservation Indians. Although the Navajo Tribe has been primarily responsible for initiating consideration of the Tax Credits, they are policies which would benefit every Indian Tribe throughout the country, including those Tribes (primarily in Oklahoma) who depend upon enterprises established on Indian Trust properties.

This brief research and background paper was assembled to provide analytical support for the Indian Tax Credit initiatives. The paper, first, illustrates the overwhelming need for policy action and provides evidence that a broad macroeconomic stimulus package without programs specifically targeted to the Indian Reservation economy will do little to improve their economic plight. Second, the paper provides what data is available to assess the costs and benefits of the two tax credits. The credits will not be applicable in every investment and employment circumstance on reservations or trust lands. Nevertheless, because of conditions unique to Indian country, carefully targeted package of tax incentives for all reservation based investments and employers would

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[1] Red Willow Institute, Applicability of Federal Tax Incentives to American Indian Reservations, Foreword to a report prepared for the National Indian Policy Center , Washington, D.C., June 21, 1991, p. iv.

have a significant impact on Tribal economies and employment, and would do so at negligible cost to the Federal Treasury.

The Poor Living Conditions of American Indians are Closely Tied to the Unemployment Problems.

For as long as the statistics have been gathered, unemployment rates among American Indians has been staggering. If one also considers the degree of discouraged workers and the fact that Indian unemployment reflects the status of families' primary wage earner, the devastating social impact can be more fully appreciated.

The 1980 Census indicated that 14 percent of Indian reservation households had incomes under $2,500 -- three times the proportion of all US households. Forty five percent of reservation Indians lived in households with incomes below the poverty level. One quarter of reservation households were receiving food stamps and one of every seven Indian households were receiving some other form of public assistance.[2] It was also reported by the 1980 Census that 21 percent of reservation Indian households had no indoor toilet facilities; 16 percent did no have electricity; and 54 percent did not have central heating. The cycle of poverty has its roots both in the extent of unemployment on reservations and trust lands as well as in the types of employment that are available.

In 1989, a year in which the average unemployment rate among all Americans was 5 percent, the unemployment rate among American Indians was 40 percent. The unemployment rates on thirteen reservations sampled by the Bureau of Indian Affairs using the definition of employment defined by the Bureau of Labor Statistics of the US Department of Labor (over age 16 and actively in the labor force) are shown in Table I:[3]

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[2] US Department of the Interior, "Report of the Task Force on Indian Economic Development," Washington, D.C., 1986. Cornell, Stephen and Joseph P. Kalt, "Pathways from Poverty: Economic Development and Institution-Building on American Indian Reservations", Malcolm Wiener Center for Social Policy at Harvard University, Cambridge, Massachusetts, December, 1989. Snipp, C. Matthew, American Indians: The First of This Land, Russell Sage, New York, 1989.

[3] Cornell, Stephen and Joseph P. Kalt, "Pathways from Poverty: Economic Development and Institution-Building on American Indian Reservations", Malcolm Wiener Center for Social Policy at Harvard University, Cambridge, Massachusetts, December, 1989, p. 5.

Table I: Reservation Unemployment Rates 1989	
White Mountain Apache	11%
Cochitl Pueblo	10%
Salish & Kootenai (Flathead)	20%
Northern Cheyenne	48%
Muckleshoot	50%
Lummi	46%
Mescalero Apache	52%
San Carlos Apache	51%
Yakima	61%
Oglala Sioux (Pine Ridge)	61%
Hualapai	45%
Crow	67%
Rosebud Sioux	90%
All Reservation Indians	40%
United States (All Races)	5%

It should be emphasized that these numbers use the BLS definition of unemployment. Only those individuals who indicate that they have been looking for work within the most recent four weeks are counted as unemployed. A more useful definition might be to estimate all Indians presently working as a proportion of those who might wish to work. Such estimates would include the so-called "discouraged worker. Estimates of Indian unemployment using this technique would be significantly higher. In 1989, the Select Committee on Indian Affairs indicated that Indian unemployment was 52 percent of the potential workforce.

Unemployment on reservations (using the BLS definition) is understated even more than the total US unemployment number. A 1987 survey in Oklahoma revealed that the labor force participation rate for Indians 16 years of age and older was 55.7 percent. The current participation rate for all Americans if working age is 66.1 percent. Even so, the proportion had increased from the 36.3 percent that had participated in the labor force in

1960. Less than half, 41.5 percent of all Indian females were in the labor force, while for Indian males the figure was 61.0 percent. Comparable figures for all Americans of working age today is 57.6 percent and 75.3 percent for women and men respectively.

The Unemployment Problem Cannot be Cured By Standard Economic Stimulus Policies.

Although the economic downturn has exacerbated the already abysmal employment statistics relating to Native Americans, the problem is a structural one and not a problem which will be cured when the US economy rebounds. This is because economic growth and recovery affects pockets of unemployment differentially.

Historically since 1966, a 3 percent closing of the "gap" between potential and actual real Gross National Product has been accompanied by a 1 percentage point decrease in the rate of unemployment. This relationship has held, more or less, until the unemployment rate has reached about 4% (so-called "full employment"). This rule of thumb, named "Okun's Law" after Nobel prize-winning economist Arthur Okun, has held for the economy in total but has not been consistent among segments within the economy. Estimates are provided in Table II below for various components of the labor force:

Table II: Responsiveness of Unemployment to Economic Growth

Workforce Segment	Reduction in Gap Required to Reduce Segment's Unemployment Rate 1 percentage point:[4]
Married Males	2.2%
Females	2.94%
Nonwhite	4.8%
Teenage	5.56%
Teenage Males	6.02%
Teenage Females	4.54%
Teenage Nonwhite	10.10%
American Indian	19.9%

These results clearly indicate that an acceleration of economic growth through stimulative fiscal and monetary policies alone is not sufficient to reduce the unemployment rate to desirable levels among some labor force segments, most certainly the American Indian segment.

Other Federal Programs Must Continue and Expand, But They Aim at Other Goals.

To reduce economic suffering, other federal programs must continue, but to permanently reduce overall unemployment they will have to be supplemented with policies designed specifically to enhance capital investment and targeted employment. Existing governmental sources of capital support are reduced due to the need for matching capital, competition from other more established businesses and the small size of the programs relative to need. Furthermore, the speed with which the grants, loans and payments can be implemented is relatively slow and has little impact on cyclical problems. The SBA loan program and the Department of Commerce Loan Guarantees for Business Development have been greatly curtailed in recent years. Bureau of Indian Affairs programs, such as the Business Enterprise Development Program constitute a minute portion of need.

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[4] Data for all segments except American Indian are from quarterly data reported by the Bureau of Labor Statistics 1966-1991. American Indian data, using the BLS definition is from data supplied by the Bureau of Indian Affairs for the years 1976-1991.

Amounts budgeted as contract authority for Indian related economic development programs (or those programs which might be construed as directly contributing to development of Indian businesses) are provided in Table III, on the following page These programs are valuable. Over time, they should be more carefully targeted and expanded. But, they prepare the worker, provide guidance to the Indian businessman, and directly employ without enhancing the basic return to capital that would enhance Indian enterprise and make it, eventually, self supporting.

The type of employment engendered by Federal spending has not been the type that jump-starts economic development generally. "Perhaps more revealing of the economic problems of reservations is the structure of the employment that does exist. Most reservation economies are heavily dependent on the 'transfer' economy, i.e., tribal or federal governmental transfer or other public-assistance programs. This can be distinguished from employment in productive enterprises (private and public) which add output to tribal economies. According to the 1980 Census, 59% of all reservation employment was in the transfer economy in 1979, compared to approximately 17% for the U.S. as a whole."[5]

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[5] Cornell, Stephen and Joseph P. Kalt, "Pathways from Poverty: Economic Development and Institution-Building on American Indian Reservations", Malcolm Wiener Center for Social Policy at Harvard University, Cambridge, Massachusetts, December, 1989, p.7. They, in turn, cite A. David Lester, "Transitions in Tribal-Federal Relations, 1989-1993", Council of Energy Resource Tribes, unpublished, 1988.

Table III. Federal Program to Promote Indian Enterprises .[6]	Fiscal Year 1990	Fiscal Year 1991
DEPARTMENT OF THE INTERIOR		
Bureau of Indian Affairs		
Economic Development and Employment Programs	$14,096,000	$14,595,000
Technical Assistance to Indian Enterprise	0	$796,000
Indian Business Development Grants	$6,907,159	$6,905,000
Indian Credit Program		
Direct Loans	$11,130,875	$8,700,000
New Loans Guaranteed	$59,132,555	$44,370,000
Bureau of Reclamation		
Loans Program	$67,000	0
Other Programs		
Indian Arts & Crafts Development	$912,000	$925,000
DEPARTMENT OF HEALTH & HUMAN SERVICES		
Jobs Program	$2,991,550	$6,263,000
DEPARTMENT OF LABOR		
Native American Employment and Training	$58,200,000	$59,600,000
DEPARTMENT OF COMMERCE		
Economic Development Administration	$2,694,000	$2,835,900
Minority Business Development--American Indian	$1,495,000	$1,495,000
DEPARTMENT OF TRANSPORTATION		
Indian Reservation Roads	$78,600,000	$80,000,000
SMALL BUSINESS ADMINISTRATION		
Contract Awards	$263,208,282	$278,304,350

[6] Table III is extracted from Stringer, William L., "The Economic Impact of Tribal Tax and Expenditure Programs in the State of Oklahoma", a paper prepared for the George Washington University Center for Native American Studies and Indian Policy Development in conjunction with the Oklahoma Indian Affairs Commission and Charles W. Blackwell, January, 1992.

Indian Businesses Have Traditionally Been in Low-Wage, Low Capital Industries.

It has only been in recent years that Tribal businesses have begun to move into areas requiring greater capital investment. A 1987 survey in Oklahoma concluded that::[7]

- The concentration of Indian-owned firms was in the construction industry (36 percent compared to 9 percent for all Oklahoma businesses). Furthermore, the concentration of Indian-owned business in the business and repair service and in the professional and related service sectors was almost twice as high as the concentration of non-Indian owned businesses in the state.

- Measured by the number of employees per firm, Indian-owned firms were significantly larger than all Oklahoma firms in the areas of agriculture, forestry and fisheries and construction. These areas constituted nearly 75 percent of all Indian employment. Indian employment was significantly smaller in the areas of mining, transportation, communications, public utilities and retail trade--those areas which require greater proportions of capital to labor.

- Construction and manufacturing account for 77.9 percent of all gross sales of Indian-owned businesses. Wholesale trade accounted for 12.9 percent and all other business sectors accounted for only 9.3 percent of the total gross sales by Indian-owned businesses. By the same token, payroll as a percent of sales was significantly less for Indian-owned firms than for all firms in Oklahoma in construction, manufacturing and wholesale trade. This would suggest either that labor is used less than capital (which is not borne out by other evidence) or that there are lower wages in Indian-owned businesses than in non-Indian owned businesses in the same sectors.

Table IV, derived from data developed by the U.S. Census Bureau for the 1982 Survey of Minority-Owned Business Enterprises: Asian Americans, American Indians, and Others provides insight into the types of businesses presently Indian-owned:

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[7] See Abudu Green, Margaret, K.W. Olson, I.M. Hayden and K.J. Selland; Report on the Economic Impact of American Indians in the State of Oklahoma; Prepared by the Southwest Center for Human Relations Studies at the University of Oklahoma; May 1987.

Table IV	Indian Firms with Paid Employees			Indian Firms Without Paid Employees		All Indian Firms		
Industrial Activity	Number of Firms	Average Number Employees	Average Gross Sales	Number of Firms	Average Gross Sales	Number of Firms	Percent of Total	Average Gross Sales
Agricultural, Services, Forestry, and Fishing	73	1.8	$93,932	2,745	$6,056	2,818	19	$8,332
Mining	12	3.2	395,667	60	59,967	72	0.5	115,917
Construction	274	3.3	201,701	1,552	18,541	1,826	12	46,025
Manufacturing	68	19.9	1,095,456	246	13,862	314	2	248,092
Transportation and Public Utilities	79	2.9	221,165	500	28,144	579	4	54,480
Wholesale Trade	19	4.5	628,105	61	39,180	80	0.5	179,050
Retail Trade	445	3.5	248,501	2,657	20,639	3,102	21	53,327
Finance, Insurance, and Real Estate	27	2.2	185,667	280	9,039	307	2	24,573
Selected Services	382	6.6	223,636	3,897	13,630	4,279	29	32,378
Other Industries	84	1.7	164,440	1,381	16,860	1,465	10	25,322
TOTAL All Industries	1,462	4.9	279,081	13,382	17,840	14,843	100	43,570

Source: United States Census Bureau; 1982 Survey of Minority-Owned Business Enterprises: Asian Americans, American Indians, and Others

Investment and Tax Credits Would Tend to Augment Capital and Reduce Unemployment.

In previous work, three general problem areas have been identified as roadblocks in the path to achieving sustained growth of employment opportunities on Indian Reservations and Trust lands: control, management and capital.[8] Although no single policy will resolve any one of the three problems, it is clear that a targeted package of policies must be created specifically for the unique set of problems facing American

[8] See, for example, the testimony of Ronald L. Trosper before the Select Committee on Indian Affairs, United States Senate, Washington, D.C., April 9, 1987, U.S. Government Printing Office, Document 75-649, 1987, p. 78. Trosper cites findings of Task Force Seven of the American Indian Policy Review Commission.

Indians.

Two types of tax credit are proposed for investment and employment on Indian Reservations and Trust lands. A capital or labor tax credit effectively lowers the after tax cost of capital or labor in a targeted type of investment, employment or geographic area. By decreasing capital or labor costs, the flow of capital to the targeted area is encouraged.

- The proposed **Indian Investment Tax Credit (ITC),** the so-called "Indian Reservation Credit", is targeted to Indian country, and specifically to reservations or sites near Trust lands where Indian unemployment levels are at least three times the national average. This would presently include most reservations and trust lands. The provisions allows a tax credit (deducted in full from pre-credit tax liability) of a stated percentage of qualified investment placed in service during the taxable year. The credit is 25 percent of the investment in reservation personal property (in association with a trade or business--and not real property), 33⅓ percent of new reservation construction property and 33⅓ percent of reservation infrastructure investment.

- The proposed **Indian Employment Tax Credit (ETC)** would be available to employers on reservations or trust lands. The credit would equal 10 percent of the wages paid (including certain health care costs) during the taxable year and 30 percent in cases where the employer has at least 85 percent Indian employees. The employer would be eligible for the credit for up to and including seven years of employment of the same employee.

The Investment Tax Credit should be viewed as a somewhat longer run policy to alter the structure of Indian owned businesses and to alter the nature and extent of structural unemployment on Reservations. The Employment Tax Credit, on the other hand, should be viewed as a policy which would have more immediate impact on reducing Tribal unemployment rates. Either tax credit can be viewed as in incentive to hire or invest both in the sense that it reduces the effective tax rate to the recipient employer and increases the rate of return on investment in capital or labor. The ITC is, of course, enhanced by more accelerated asset depreciation although its impact on the effective tax rate, given the same percentage of application, is much greater.[9] A simple example will suffice to illustrate the basic concept,:

> If an piece of machinery or infrastructure requires a one-time payment of $9,000 at the beginning of a year, and provides a cash flow of $1,300 for each of the next ten years (the useful life of the equipment), then the pre-tax rate of return on that

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[9] See, for example, Congressional Budget Office, Revising the Corporate Income Tax, Congress of the United States, Washington, D.C., May, 1985, pp. 89-91.

investment is 7.31 percent. Of course the after-tax rate of return would be less, because the income stream produced by the investment would be reduced by the annual tax rate times the incremental annual increase in revenue caused by the investment (less any depreciation allowance). If the going rate of interest on the money used for the investment were 8 percent annually, then the investment in the equipment would not be made. If, however, a 33⅓ investment tax credit were allowed in the first year then the pre-tax return on investment would grow to 15.49 percent, because $3,000 (⅓ of $9,000) would be recaptured as a tax credit at the end of the first tax year. Again, the after-tax rate of return would be reduced by the tax liability (less the depreciation allowance) on the income flow occasioned by the investment. By analogous reasoning, the Employment Tax Credit will enhance the return to the employer of hiring additional units of Indian labor.

Because of the concentration of Tribal employment in labor intensive, low wage industries:

(1) Tribal employment is particularly susceptible to cyclical downturns in the economy. Thus, any policy which would shift Tribal industry to greater capital intensity would reduce cyclic volatility.

(2) The Employment Tax Credit would have an immediate impact on employment levels. The industries affected have relatively large employment and income multipliers which would tend to cause tax expenditure increases and reductions in entitlement payments beyond what they would otherwise be.

By using the US average capital to labor ratio in the industries with concentrations of Indian workers, one can estimate that the at least six and one half billion of investment would have to be induced to employ the unemployed Indian workers for the duration of their working years--about $36,600 per unemployed Reservation Indian worker. Applying the prevailing capital to income ratio to the income gap between Indians and the general population, it would require an investment of about twelve billion, or about $67,600 per unemployed American Indian. "Tangible real capital owned by Indians, plant, equipment, and inventories would have to increase that much from its current level to get Indian incomes and jobs up to national standards."[10] The proposed Indian targeted ITC and ETC would have nowhere near the required impact, but it would be a significant step.

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[10] The technique follows that of Ronald L. Trosper before the Select Committee on Indian Affairs, United States Senate, Washington, D.C., April 9, 1987, U.S. Government Printing Office, Document 75-649, 1987, pp. 87-88. In this instance, Trosper cites a 1986 Compendium published by the Select Committee on Indian Affairs of the United States Senate.

The Nature of Indian Businesses, the Reduction of Entitlement Payments to Tribal Members and Economic Multiplier Effects, Make the Cost of the Credits Minimal and, Perhaps, Negative.

Because of (1) the structural nature of Tribal unemployment, (2) the fact that Tribal businesses generally operate in geographically isolated areas, and (3) because potential employment would occur in companies with little excess capacity Tribal unemployment would uniquely benefit from either an investment tax credit, an employment tax credit, or both. And, because of these factors, the cost to the US is minimal or even negative.

Direct Costs of the Employment Tax Credit. The 1990 Census counted 1,957,191 American Indians in all 50 states. If seventy five percent of those are over age 16, and 55 percent of these were in the labor force, then a 40 percent unemployment rate would imply that 322,937 Indian workers were unemployed. If 55 percent of these unemployed workers would otherwise depend on employment on reservations or trust land, then 177,615 Indian workers stand to directly benefit from the two tax credits.

If all 177,615 were hired as a result of the proposed Indian Employment Tax Credit at an average wage rate of $8.00 per hour; and one half of those employed were employed by firms having employment of at least 85% Native Americans; then the immediate revenue loss--without accounting for reduced entitlement payments and unemployment compensation, taxes levied against the wage earner, additional taxes garnered as a result of enhanced output and various multiplier effects--the cost to the US Treasury would be in the nature of $591.2 million.

Of course, one would not expect anywhere near full employment of the unemployed Indian worker as a result of the ETC. For one reason, manufacturing firms located on Indian Reservations, the largest employer (as can be seen from Table IV) do not pay Federal taxes and, therefore, could not avail themselves of the credit. At the same time, there would be no additional costs to the Treasury for manufacturing firms. Under the same assumptions, with 10 percent participation, as seems reasonable, the Treasury direct loss would be $59 million. Indirect benefits would be marginally higher wages and sustained employment within permanently viable firms.

Direct Costs of the Investment Tax Credit. In 1990, expenditures by tribally owned and Indian owned businesses in the State of Oklahoma (having 12.8 percent of the total US Native American population) were estimated to be $565 million (wages, investment in property, equipment and wages).[11] If fifteen percent of that spending were on investment

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[11] See Stringer, William L. , "The Economic Impact of Tribal Tax and Expenditure Programs in the State of Oklahoma", a paper prepared for the George Washington University Center for Native American Studies and Indian Policy Development in

in ITC qualifying personal property, construction property, and infrastructure; and, if Tribes in the other 49 states spent similar amounts in proportion to their population; then total qualifying Indian investment in 1990 would have been about $659.9 million.

Even if every dime were applied as a 33⅓ percent credit--without accounting for reduced entitlement compensation, taxes levied against the equipment supplier, additional taxes garnered as a result of enhanced output and various multiplier effects--the tax loss would be $217 million. In reality, because of the nature of Indian and tribally owned businesses and the general economic condition of the Tribal economy, the immediate, first round, loss would be considerably less.

Direct Entitlement Program and Tax Offset. Whereas the credits have a duration of one year in the case of the ITC, or seven years in the case of the ETC, the flow back to the Treasury of reduced entitlement payments, unemployment compensation, and tax revenue would continue over the useful life of the equipment, or the employment period of the worker. The repayment flow to the Treasury can, thus, compensate the Treasury many times over for the original investment. An accurate assessment would require a calculation of the present value of costs to the Treasury (one year in the case of the ITC and seven years in the case of the ETC) less the present value of all entitlement and increments to tax payments over the lifetime of the worker.

In testimony before the Select Committee on Indian Affairs of the Untied States Senate, Ronald Trosper outlined the calculus which gives rise to the above conclusion:[12]

> In 1986 the Interior Department's Task Force on Indian Economic Development collected data on the costs of AFDC, Food Stamps, commodities, and general assistance on a state-by-state basis, using the actual rules in practice. They also examined income tax payments under the prevailing tax rates. The computed that an investment of $10,000,000 which created jobs for 300 unemployed heads of households would lead to a combination of tax receipts and welfare savings for the federal government and for states that would amount to approximately $1,769,000 per year. On an investment of ten million dollars, that gives an accounting rate of return of 17.6 percent per year. The economic rate of return would be higher, because there would be increased profit and wage income as well.

The following example illustrates the reflows associated with employment of an otherwise

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conjunction with the Oklahoma Indian Affairs Commission and Charles W. Blackwell, January, 1992.

[12] Ronald L. Trosper before the Select Committee on Indian Affairs, United States Senate, Washington, D.C., April 9, 1987, U.S. Government Printing Office, Document 75-649, 1987, pp. 87-89.

unemployed Tribal household:

> A family of 2 unemployed adults with 2 children annually receives approximately $3,500 in Native American General Assistance and $3,500 in food stamps, and may, additionally, pay $1,000 per year for subsidized housing. If one parent obtains a job providing effective compensation of $8.00 per hour, after-tax annual income would be $14,900. But the Federal government no longer pays to the family nearly $7,000 in benefits. In addition, the housing rent can justifiably increase to about $4,000. Thus the $16,640 of pre-tax income is reduced $7,000 by the elimination of entitlement payments, $3,000 for housing payments, and about $2,800 of income tax and FICA taxes.

In the above example, which is typical of many Reservation Indians, the worker exchanges an effective $10,000 welfare income for a $14,900 working income--but the federal government increases its tax revenue and reduces its out-of-pocket expenses for this year and, presumably, for each subsequent year by an amount of $12,800. If the inducement were the Indian Employment Tax Credit, then the Treasury tax-credit revenue loss, at most (the 30 percent category), was $4,499 for a return of $12,800 for each year of work.[13].

Indirect Multiplier Offsets. The net stimulus to the local economy would be equal to the difference between the government payments prior to employment and the worker's income after employment--$4,900 in the above example. This stimulus, in turn, would be spent a number of times over, giving rise to a certain "multiplier effects". To the extent that business activity were simply moved from a non-Reservation place of business to a Reservation business, the overall macroeconomic impact would be negated. However, the isolated nature of Indian business and the closed nature of the businesses causes the substitution to be much less likely.

The Bureau of Economic Analysis of the US Department of Commerce has estimated the multipliers for each industrial category for each of the fifty states. Although a complete multiplier analysis is beyond the scope of this paper, an additional $4,900 earned by each of 177,615 unemployed, Reservation-oriented, Tribal members, using an earnings multiplier of about .75 (in line with estimates of the Department of Commerce model) would enhance the Federal Treasury by about $117.5 million.

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[13] This example is updated from an example provided by Eric Rice in Hearings before the Select Committee on Indian Affairs of the United States Senate, May 1, 1990, "Indian Economic Development; Indian Employment Opportunity Acts of 1989; and the Supreme Court's Decision in Cotton Petroleum Corp. v. New Mexico", Government Printing Office, Washington, D.C., 1990, p. 90.

Summary and Conclusions.

This brief report, aimed at supporting the Indian Tax Credit initiative of the Navajo in conjunction with Congressional examination of the Tax Stimulus Initiative, has underscored the pressing need for tax policies designed to stimulate growth of Reservation and Trust land enterprises. Deepening of capital intensity through the Indian Investment Tax Credit is a technique to foster both short and longer term growth. Employment of Native Americans, suffering from unemployment rates averaging 40 percent of the work force, would benefit in a much shorter time frame from enactment of an Indian Employment Tax Credit. Both credits are needed to counter the bleak short and long term outlook for American Indian employment. Standard fiscal and monetary policies to stimulate overall U.S. economic growth will have little effect on the employment and living conditions of American Indians unless they include programs which are targeted to the benefit of the American Indian.

- Six to twelve billion dollars of capital investment would be needed to eliminate all unemployed Native Americans. On average, 40 percent of the Indian workforce is unemployed and a far greater number is underemployed and have dropped out of the labor force.

- Existing Federal programs are meager compared to the level of need and, although useful to meet other goals, are not geared to making Indian businesses self sustaining generators of employment opportunity. This paper identified 13 Federal programs designed to assist Tribal enterprise, but none provide the type of sustained support inherent in a Tax Credit policy.

- Tribal employment is particularly susceptible to cyclical downturns in the economy. Thus, any policy which would shift Tribal industry to greater capital intensity would reduce cyclic volatility. The Employment Tax Credit would have an immediate impact on employment levels.

- Even if the Employment Tax Credit were used to hire every unemployed and qualifying Native American, the one-year direct costs to the U.S. Treasury would be only $591.2 million--$3,328 per unemployed American Indian. At best (given the history of the targeted employment tax credit enacted in 1978) the employment credit could be used to employee 10 percent of the eligible population, meaning that the cost to the Treasury (prior to accounting for offsets) would be $59 million.

- Even if all investment made by Tribes or Indian owned business was eligible for the Investment Tax Credit the loss to the U.S. Treasury would be about $217 million. Because many investment opportunities on Indian Reservation cannot use the Investment Tax Credit, and because of overriding economic considerations, it is more likely that 15 percent or less of the potential tax expenditure would be drawn upon. This would mean a cost of the Treasury (prior to accounting for offsets) of about $32.6 million.

- The revenue loss would be more than made up for by reduced General Assistance payments, reduced Food stamps, increased rental payments for subsidized housing, increased income tax payments and increased FICA payments. For a household of two non-working parents with two children their is a reduction in the U.S. Budget deficit of $12,800 (to net against the $3,328 paid under the Employment Tax Credit, for example). Multiplier effects would add an additional $117.5 million to the U.S. Treasury. And, most importantly, these amounts would accrue year after year, whereas the costs are for one year, in the case of the Investment Tax Credit, or for seven years, in the case of the Employment Tax Credit.

William L. Stringer is President of Economic and Financial Consultants, a Washington, D.C. based public policy consulting firm. He attended the University of Kansas for his undergraduate education and Oklahoma State University for graduate work and since then, has taught economics and finance at various universities. He served as Chief Economist of the United States Budget Committee and as Assistant to the Chairman of the Federal Home Loan Bank Board. Subsequently, he was Deputy Treasurer and Acting Treasurer of the State of New Jersey. He was Partner and Senior Vice President of the American Capital Group, a public finance advisory firm operating out of Philadelphia and was Vice President of Chambers Associates, a Washington, D.C. based public policy consulting firm. He presently is on the graduate faculty of the Fels Center for Government at the University of Pennsylvania in Philadelphia and provides independent private consulting in matters relating to economics and finance from his office in Washington, D.C.

The **George Washington University Center for Native American Studies and Indian Policy Development**. The National Indian Policy Center Planning Office was established by congressional initiative and authorized by Public Law 101-301. The legislation, supported by a number of tribal leaders, provided for a Policy Center planning office to be located at George Washington University in Washington, D.C. The Policy Center is undertaking a year-long consultation with American Indian and Alaska Native governments and individuals to develop the purpose, structure and function of a research and analysis institution of social, economic and legal policy development on Native issues. The ultimate goal of the consultation process is to develop a final report on the feasibility study that will serve as a framework for federal authorizing legislation in the 102nd Congress.

The National Indian Policy Planning Office operates under the direction of a Planning Committee comprised of nationally prominent tribal leaders and representatives of major Indian organizations. Recommendations and support are not limited to Native governments and national organizations; individuals are also invited to participate in the development of the Center.

STATEMENT OF OPPOSE

Members of the Senate Finance Committee, I am Robert J. Scott, Secretary/Treasurer of OPPOSE. OPPOSE is a Colorado Corporation formed by teachers, firefighters, police officers, and other state and local government employees who have elected not to join the Social Security/Medicare system. The purpose of our organization is to assure the continued financial integrity of our members' retirement and health insurance plans by resisting efforts to mandate Social Security or Medicare coverage of public employees. Our members are found in Alaska, California, Colorado, Illinois, Kentucky, Louisiana, Massachusetts, Minnesota, Nevada, Ohio, and Texas. With respect to the issue of mandatory Medicare and Social Security coverage, the interests of OPPOSE are identical to those of the four to five million full-time public employees throughout the nation who remain outside the Social Security System.

BACKGROUND

In its budget for fiscal year 1993, the Administration again proposes raising revenues (estimated at $1.6 billion in 1993 and $1.5 billion per year for the period 1994-1997) by imposing mandatory Medicare coverage upon all state and local government employees who are not now covered by Medicare. This tired measure has been proposed nearly each year since 1986, when Congress enacted a phase-in of mandatory coverage by requiring coverage of newly hired state and local government employees. We believe that the compromise adopted in the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") should be respected and that our employees and retirees should not be visited by the same threat year in and year out. Therefore, and for the further reasons set forth below, we ask you once again to reject the proposal to mandate Medicare coverage of all state and local government employees.

PROBLEMS RAISED BY PROPOSED MANDATORY COVERAGE

I. The President's budget proposals would make the federal tax system less progressive than it already is, would frustrate efforts to provide tax relief for middle income taxpayers, and would impose a significant new tax burden upon many of the people who can least afford new taxes.

The proposal to impose mandatory Medicare coverage upon all state and local government employees would affect over two and one-half million Americans who earn an average salary of approximately $28,750, as well as their families. These individuals---primarily teachers, firefighters, police, and other public employees---can ill afford the burden of federal taxes increased, on average, by $415 each year ($28,750 multiplied by the HI tax rate of 1.45%). (See attached Table A setting forth state by state the cost of medicare coverage to the affected individuals.)

There has been great concern in the current Congress about the problems of the middle class. There have also been significant questions about whether the middle class has been asked to shoulder too much of the Federal tax burden, in proportion to its ability to pay. Prominent members of Congress have introduced legislation which would provide members of the middle class with tax cuts in a range of $200 to $400 per household, and there has been serious concern that there may not be room in the budget to provide even this amount of limited relief.

If the members of the middle class are burdened , the President's proposals with regard to mandatory medicare would make a bad situation worse. Data released by the Treasury Department in 1990 reveal that, as a result of the Tax Reform Act of 1986, taxpayers with adjusted gross incomes under $50,000 received a net tax cut of $9 billion between 1986 and 1987. Now the Administration proposes to raise revenues of $1.5 billion annually--or 17 percent of the net tax cut received by all Americans with incomes under $50,000---from public servants who generally make much less.

Most public employees fall in the second and third quintiles of income. These are families whose average income ranges from about $20,000 per year to about $32,000 per year. Studies based upon CBO data and prepared by the Ways and Means Committee staff indicate that many of these families actually lost ground during the period 1977 through 1989 or, at best, have progressed only minimally. For example, the second quintile, those between the 20th and 40th percentiles in terms of average family income, actually lost about 1.7 percent in after tax income, measured in constant dollars, during this thirteen year period. Those in the third quintile, ranging between the 40th and 60th percentiles in average family income , fared somewhat better, but still realized income growth of less than half a percent per year, uncompounded, throughout this period. Federal income tax rates, as a percentage of pretax income, actually increased slightly for the fourth quintile income group. (For the third quintile income group federal tax rates were essentially unchanged.) People at this level of income should not be called upon to pay additional taxes; the people who would be affected simply cannot withstand this type of hit.

The effects of mandatory Medicare can be illustrated by looking at the impact on an average Illinois teacher. This person has before tax income of just over $33,000. Expenses include food ($4,315), housing ($7,837), clothes ($1,357), transportation ($4,794), health care ($1,336), entertainment ($1,356), other items, such as charitable contributions, books and education ($2,518), insurance ($355), pension plan contributions ($2,642), state taxes of $991, and federal taxes of $4,307. Added together expenses total about $31,800. But even this careful budget leaves only about $1,200 for contingenies, which are almost certain to occur in real life situations. By really scrimping on items like transportation, clothes and entertainment, the teacher can just about make it. Yet the Administration proposes to add an additional tax burden of $479.

II. The proposals would hurt badly the ability of already strapped state and local governments to deliver services. Those who are most dependent on government services as a safety net would be most affected.

Other people besides government employees, many of them very poor, would also be hurt badly by mandatory Medicare because state and local governments are in such desperate shape financially. State reserve balances, or so-called rainy day funds, are at their lowest level in recent memory, including 1983, the low point of the last recession. Two states, California and Michigan, were actually forced to decrease AFDC relief for fiscal 1992. Other states, including nearby Maryland, reduced other safety net programs. Yet on January 9, 1992, The Washington Post published an article suggesting that California will still face a deficit of $6 billion this year, while New York faces at least $6.5 billion in red ink. The states, collectively, have raised taxes by about $25 billion in the last two years. This will be a difficult pace to maintain. The formula is extremely simple; increased costs mean decreased services virtually everywhere. Those services will be in areas

that people are likely to notice---public safety, education, libraries, public health, and infrastructure.

Measured in this situation, mandatory Medicare's cost would be tremendous. (See attached Table B setting forth state-by-state the cost of Medicare coverage of those employees currently not covered.) Some of the highest costs would be paid by states that are already reeling; California, $304 million; Connecticut, $18 million; Illinois, $73 million; Louisiana, almost $50 million; Massachusetts, $84 million; Ohio, $135 million and Texas, $96 million. Other states would be paying amounts which are small in comparison, but which may loom large in proportion to their current fiscal strength. Of course, not all of the problems would be borne directly by the states. Cities and counties would also suffer serious pain and, particularly in the case of older urban centers, their fiscal situation has already been stretched beyond the point where they are able to function effectively.

A January 1992 survey by the National League of Cities entitled The State of America's Cities that about twenty percent of elected municipal officials throughout the United States expect the quality of their city's services to decrease in 1992. Almost an equal number believe that deterioration can be avoided only if there are local tax increases this year. Slightly over half reported that overall local economic conditions had deteriorated in 1991.

III. President Bush has vowed to leave a legacy as "the Education President" leading the effort to improve the quality of education; yet the mandatory coverage proposals would have a particularly adverse effect upon education in America.

Within the past several years, the National Commission on Excellence in Education declared that America's educational system is failing both its students and the entire country. It has been recognized that one cause is the difficulty school systems face in recruiting quality teachers. The federal government has reported that the country will have 34% fewer teachers than it needs, possibly as early as this year.

One reason for this problem is that teachers are significantly underpaid. In 1990 the average elementary and secondary school teacher's salary was $32,000, while in many states the average teacher compensation still hovers in the low twenties.

Mandatory Medicare would only exacerbate the problem caused by low salary levels. Teaching is one of the major professions with large numbers of non-covered members. In the affected states mandatory Medicare coverage would take an additional $ 464 from the average teacher's salary each year (1.45% of $32,000). As a result, many of the best qualified teachers---particularly those with marketable skills in mathematics, science, and computers---would leave teaching for better paid employment.

In sum, in a time in which education is to take top priority, it would be unwise to adopt legislation that would aggravate the teacher recruitment problem and further increase the cost of education for both students and schools.

IV. Mandatory coverage can not be justified on the grounds that it would benefit the affected employees.

Some have argued that public employees would actually benefit by receiving mandatory Medicare coverage. The response to this concern is simple: if public employees wanted Medicare coverage, they would be clamoring for it. Since passage of COBRA, local jurisdictions have had the option of joining the Medicare system

without also participating in the Social Security System. In short, if Medicare coverage were desirable, employees would certainly bring pressure to bear upon their employers (which are, after all, elected governments) to adopt it. In fact, the opposite is true; far from clamoring for Medicare coverage, public employee groups are vehemently opposed to efforts to impose these programs upon them. They do not need the federal government to provide these programs "for their own good."

V. Mandatory Medicare coverage of the employees who were "grandfathered" outside the system by COBRA would create a variety of problems that were avoided by COBRA's compromise position.

Some state and local governments have health plans in place for their employees, including retirees. Adjustment of these plans to take account of Medicare coverage for existing employees would create an overwhelming task, or would result in the abandonment of these plans. While the phase-in provision adopted in COBRA affects the health benefits and take home pay of individuals at the time they commence employment, the Administration's proposal would displace benefits programs that individuals have enjoyed, in some cases, for many years, and would reduce the amount of take home pay they have come to expect. Abandonment of the careful compromise adopted in COBRA would unfairly disappoint the expectations of millions of public workers.

For all of these reasons, the Administration's proposal to mandate Medicare coverage of all state and local employees should be squarely rejected.

Thank you for allowing me the opportunity to present the views of OPPOSE.

January 1992 Table A

ANNUAL COST TO STATE AND LOCAL GOVERNMENT EMPLOYEES OF MANDATORY COVERAGE OF ALL EMPLOYEES

State	Annual Salary of Average Public Employee/1	Annual Tax Increase Resulting From the Proposal/2
Alabama	$ 22,764	$ 330
Alaska	42,216	612
Arizona	29,832	433
Arkansas	20,112	292
California	37,248	540
Colorado	28,956	420
Connecticut	34,980	507
Delaware	28,104	408
District of Columbia	36,288	526
Florida	26,412	383
Georgia	23,028	334
Hawaii	28,416	412
Idaho	22,512	326
Illinois	29,724	431
Indiana	26,040	378
Iowa	27,660	401
Kansas	24,132	350
Kentucky	23,256	337
Louisiana	21,924	318
Maine	25,272	366
Maryland	32,604	473
Massachusetts	30,600	444
Michigan	32,496	471
Minnesota	31,848	462
Mississippi	19,548	283
Missouri	24,312	353
Montana	23,940	347
Nebraska	25,008	363
Nevada	30,624	444
New Hampshire	27,108	393
New Jersey	32,904	477
New Mexico	22,860	331
New York	34,152	495
North Carolina	25,860	375
North Dakota	25,248	366
Ohio	27,636	401
Oklahoma	22,020	319
Oregon	27,792	403
Pennsylvania	28,944	420
Rhode Island	31,524	457
South Carolina	22,692	329
South Dakota	21,840	317
Tennessee	23,220	337
Texas	24,096	349
Utah	24,624	357
Vermont	26,184	380
Virginia	27,048	392
Washington	29,952	434
West Virginia	22,584	327
Wisconsin	28,848	418
Wyoming	25,080	364

1/ The most recent data available was obtained from the U.S. Bureau of the Census, Public Employment 1990 - Government Employment (Series GE-90-1) at 10.

2/ The amount of the new Medicare tax is derived by multiplying the average employee's salary by 1.45 percent.

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January 1992

Table B

ANNUAL COST TO STATE AND LOCAL GOVERNMENTS OF COVERAGE OF THOSE EMPLOYEES CURRENTLY NOT COVERED BY MEDICARE

State	Employees Not Covered by Social Security/1	Employees Not Covered by Medicare Number/2	Percentage/3	Cost of Coverage (Millions)/4
Alabama	27,000	15,336	6.0	5.1
Alaska	40,000	22,720	45.6	13.9
Arizona	21,000	11,928	5.6	5.2
Arkansas	39,000	22,152	15.8	6.5
California	991,000	562,888	33.2	304.0
Colorado	150,000	85,200	38.2	35.8
Connecticut	63,000	35,784	20.1	18.2
Delaware	14,000	7,952	18.5	3.2
District of Columbia	0	0	0.0	0.0
Florida	127,000	72,136	9.8	27.6
Georgia	64,000	36,352	8.7	12.1
Hawaii	24,000	13,632	19.0	5.6
Idaho	0	0	0.0	0.0
Illinois	299,000	169,832	25.0	73.2
Indiana	54,000	30,672	9.1	11.6
Iowa	5,000	2,840	1.4	1.1
Kansas	2,000	1,136	0.6	0.4
Kentucky	56,000	31,808	15.2	10.7
Louisiana	271,000	153,928	57.3	48.9
Maine	52,000	29,536	36.6	10.8
Maryland	29,000	16,472	5.8	7.8
Massachusetts	334,000	189,712	57.5	84.2
Michigan	19,000	10,792	1.9	5.1
Minnesota	96,000	54,528	18.4	25.2
Mississippi	2,000	1,136	0.7	0.3
Missouri	62,000	35,216	12.1	12.4
Montana	5,000	2,840	4.2	1.0
Nebraska	2,000	1,136	0.9	0.4
Nevada	49,000	27,832	40.7	12.4
New Hampshire	6,000	3,408	5.4	1.3
New Jersey	30,000	17,040	3.6	8.1
New Mexico	33,000	18,744	16.4	6.2
New York	153,000	86,904	6.6	43.0
North Carolina	43,000	24,424	6.0	9.2
North Dakota	6,000	3,408	6.4	1.2
Ohio	595,000	337,960	53.5	135.4
Oklahoma	33,000	18,744	8.9	6.0
Oregon	14,000	7,952	4.2	3.2
Pennsylvania	36,000	20,448	3.6	8.6
Rhode Island	25,000	14,200	26.5	6.5
South Carolina	6,000	3,408	1.6	1.1
South Dakota	2,000	1,136	2.1	0.4
Tennessee	29,000	16,472	5.8	5.5
Texas	486,000	275,480	26.8	96.3
Utah	1,000	568	0.5	0.2
Vermont	1,000	568	1.5	0.2
Virginia	72,000	40,896	10.6	16.0
Washington	36,000	20,448	6.9	8.9
West Virginia	7,000	3,976	3.8	1.3
Wisconsin	48,000	27,264	8.4	11.4
Wyoming	5,000	2,840	6.6	1.0
	4,564,000	2,591,784		1,113.7

1/ Social Security Administration, 1985 Current Population Survey and Continuous Work History Sample, reprinted in Congressional Research Service paper "Medicare Coverage of Employees of State and Local Governments," by David Koitz (March 11, 1987).

2/ The Consolidated Omnibus Budget Reconciliation Act of 1986, Pub. L. 99-272, requires public employees hired after March 31, 1986, to participate in the Medicare system. Because we assume employee turnover occurs at a rate of approximately 9% per year, in the five and a half years since COBRA took effect, approximately 43.2% of previously non-covered public employees are now covered by Medicare. The number of public employees not covered by Social Security has therefore now been reduced by 43.2% to reflect the number of employees who are currently not covered by Medicare.

3/ These figures reflect the percentage of the total number of state and local employees by state who would be affected by mandatory Medicare coverage.

4/ The figures reflect only the 1.45% that would be paid by the governments as employers, and do not include the cost increase to their employees, who would also have to pay the 1.45% Medicare tax. (See Table A for increased tax burden on individual employees.) Given that the employer's part of the Medicare tax is 1.45%, this is multiplied by the average state or local government employee's salary for each state (U.S. Bureau of the Census, Public Employment in 1990 - Government Employment, Series GE-90-No. 1); each governmental employer's cost is equal to the number of employees, multiplied by the average salary, multiplied by 1.45%.

STATE OF COLORADO

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Roy Romer
Governor

February 20, 1992

The Honorable Lloyd Bentsen
United States Senate
SH-703 Hart Senate Office Building
Washington, D.C. 20510-4301

Dear Senator Bentsen:

Thank you for the invitation to appear before the Senate Finance Committee to discuss the health aspects of the President's budget. I am sorry that my schedule would not permit me to appear personally, but I appreciate the opportunity to comment through this letter.

The President's proposal is a welcome acknowledgement that we have a health care crisis in this country. Still, it falls short in addressing the fundamental problems of America's failed health care system.

While I have a number of concerns about the President's proposal, I will focus my comments on Medicaid and the effect of the proposal on states. Medicaid has been carrying an ever-increasing burden as more and more people are shut out of the private health insurance market. Unless we fix the private market which serves most Americans, Medicaid budgets will continue to grow. Clamping down on Medicaid spending without fixing the private market, which is what the President's proposal does, will simply accelerate the trend of shifting costs from the federal government to state and local taxpayers, and to the private sector.

Under the President's plan, Medicaid would change from an open-ended entitlement to a capped entitlement for the non-elderly poor. This change in funding would be accomplished through the imposition of federal per capita limits on spending and through predetermined (but as yet unspecified) limits on program growth. Also, the basic structure of the program would change from a fee-for-service model to a coordinated care model. Both of these approaches have important implications for state Medicaid programs.

As reported in the President's budget, Medicaid spending is expected to increase about 38 percent this fiscal year and is projected to increase at 17 percent a year for the next several years. While case load increases clearly contribute to this growth, health care inflation is an important contributing factor as well. The President would restrict growth in the per capita limit to the Consumer Price Index plus 2 - 4 percent. Under current conditions, this would allow a 7 percent annual growth. States are asked to accept this limit without any clear indication of how the plan would control national health care costs. In the near future, states could easily find

themselves eliminating optional services to keep within the federal per capita limit, and eliminating optional eligibility groups to keep the overall program from further consuming our state budgets. The President should expand his model to include other cost control measures as well as financial safeguards for the states so that we would not be placed at further risk.

The President's plan imposes a per capita limit on the non-elderly, non-disabled population. In other words, the President has chosen to impose his per capita limit on services for poor women and poor children. It is with this very population that the Congress and the states had their greatest success in providing access to health coverage. The current proposal places women and children at undue risk and may reverse health gains made in the last five years.

I appreciate the President's desire to control the cost of the Medicaid program -- both for the federal government and for the states. Unfortunately, we know that reductions in Medicaid reimbursement rates simply lead to higher charges for all other payors. If the President really wants to contain the Medicaid budget expansion, he must support a fundamental, structural reform of America's health care system that includes a strong cost-containment feature.

The President also proposes changing the basic structure of the Medicaid program from one in which beneficiaries are free to choose their physicians to one in which access to physicians would be limited through coordinated care programs. While I support managed care programs as vehicles to contain costs, most states would need time to establish capacity, especially for services provided through health maintenance organizations or other pre-paid capitated models. Moreover, additional examination of quality of services under coordinated care models is needed before mandating such a transition.

The President has proposed a second Medicaid option that would give states flexibility to establish alternative, comprehensive, state-based health programs. This option is consistent with our states' commitment to serve as laboratories for testing comprehensive health care reform.

However, when we reform our systems, we will be constrained by the Medicaid financing model established at the federal level. Without assurances of adequate financing, states will be unable to develop their best alternatives.

I want to thank you and the committee for giving me the opportunity to comment on the President's Medicaid proposal. I am committed to a comprehensive approach to our health care dilemma. I look forward to working with you, your committee, the congressional leadership and the President in improving America's health care system.

Sincerely,

Roy Romer
Governor

Statement of the Savers & Investors League

THE ORDINARY INCOME TAX TREATMENT OF SAVING MAKES NO SENSE

GREATLY EXPANDED AND IMPROVED IRAS ARE THE ANSWER

The Savers & Investors League's purpose is to educate and motivate grass roots voter/taxpayers so that they may claim their rightful role in influencing the way our government taxes their hard-earned saving.

We appreciate the opportunity to present our strong views on tax policies that will provide middle-class tax relief and expand our nation's economic growth. We will also state our views as to those existing tax policies that are killing our nation's economic growth and the growth of middle-class living standards.

Renewed concern over the level of personal saving has led to interest on the part of the public, the Congress, and the Administration in enhancement of IRAs or some related form of saving incentive. Many members of this Committee have co-sponsored legislation to improve IRAs.

In view of this important interest, this testimony seeks to present a new and improved analysis of how IRA-type plans overcome the income tax bias against saving. By promoting saving, greatly improved IRAs will expand future income and GNP, benefiting individuals and the nation as a whole. Only when the positive economic growth and revenue effects of IRAs are recognized and understood by our tax policy officials, Congress, and the public, will a rational legislative action be taken to overcome the present tax bias against saving.

It is important to recognize the difference between: (a) the "ordinary income tax treatment of saving," in which income is taxed before it is first saved, and then the earnings are taxed each year thereafter; and (b) the "tax treatment accorded IRAs," in which the tax on income is deferred (via a tax deduction), as is the tax on reinvested IRA earnings. Such IRA deferrals continue until the accumulated IRA values are withdrawn for consumption (spending), at which time they are taxed at ordinary income tax rates.

The marked difference between (a) the ordinary income tax treatment of saving, and (b) the tax treatment of saving under an IRA can best be illustrated by tracing the growth, at market rates of return, of a sum of money saved at some point in time when subject to the ordinary income tax and when treated as an IRA. Ideally, the illustration would cover a lengthy time period and would, therefore, show the effects over time on individuals and on government tax revenues of the different tax treatments on accumulated saving.

In order to produce an illustration based on actual free market rates of return available historically to savers in the United States over a long time period, we have selected a fairly typical mutual fund to be our representative saving vehicle. The fund chosen has been in operation since 1926, and provides an example of a real-life investment available to the general public and stretching over a sixty-five year period spanning depression, wars, recessions, and prosperous years of peace. All figures shown herein are based on the actual investment performance and yearly distributions of this fund. (Similar analyses based on a number of other mutual funds, not illustrated, show similar results in regards to the impact of taxes upon saving.) The methodologies used in creating the financial results portrayed herein have been reviewed and approved by a Fellow of the Society of Actuaries.

These illustrations reveal *first* that the ordinary income tax drains away an enormous portion of the accumulation of saving that would otherwise build up in a tax-free environment (Table 1). Next, the illustrations also reveal that under reasonable assumptions, the government's tax revenue would be greater over time if it did not tax the earnings of savings each year, but let them build up over time until taxpayers withdrew them for consumption (spending) [Table 2—IRA Tax Treatment]. The last illustration presents a comparison between IRA-type taxation *vs* the ordinary income tax treatment of saving (Table 2 minus Table 1). The enormous gains from IRAs *vs* the ordinary income tax become clearly evident in Table 3.

The illustrated gain to the government from IRA-type taxation reflects the higher taxes that would be collected over time on the earnings of the original amount saved, and is the direct result of (a) tax deferral, and (b) the fact that the rate of return on private saving in the economy is higher than the rate of interest the government would have to pay to borrow to cover the taxes deferred.

Let us focus on two of these illustrative tables to drive home two extremely important points: (a) the ordinary income tax is an economic cancer that gradually eats away and emaciates our nation's economic strength (Table 1); and (b) IRA-type tax treatment, when compared with the ordinary income tax treatment of saving, provides enormous financial and economic gains for voter/taxpayers, our government, and our nation (Table 3).

The Ordinary Income Tax Treatment of Saving

The figures in Table 1 reflect a taxpayer's $100 of "after-tax" saving that's invested in the mutual fund. The Table below has been created by multiplying all of the relevant figures on Table 1 by $10 million. This permits us to illustrate the gigantic drain of investment growth that arose over the years from **each $1 billion** of U. S. taxpayers' long-term saving. [$100 x $10 million = $1 billion]. A 50% tax bracket has been included for illustrative purposes, because such a bracket was used during many, if not most, of the indicated durations.

The Nation's **Loss** of Investment Growth
Due to the Ordinary Income Tax
The **Losses** from **Each $1 Billion** of Saving

	Year Investment Made and Duration		
	1981	1961	1926
Tax Bracket	10 Years	30 Years	65 Years
15%	$69 Million	$1.6 Billion	$292 Billion
31%	$138 Million	$3.0 Billion	$487 Billion
50%	$215 Million	$4.3 Billion	$628 Billion

These losses occur, because all ordinary income tax collections from the return on saving remove forever any subsequent free-market return and tax thereon. It is understandable why these losses are often called "dead-weight losses"; they act as an economic millstone around our nation's neck.

Ponder the meaning of these huge losses shown above from **each $1 billion** of saving when one considers the **billions and billions of dollars** that have been subjected to the ordinary income tax over the years!

It is obvious, too, from the above illustration that the more you tax away each year, the less there is to tax thereafter. Thus, the larger the tax bracket, the greater the accumulating losses for our nation—and for all of us, including our government's tax revenue! By utilizing the ordinary income tax treatment of saving, the government cuts off its nose to spite its face! And, at the same time, cuts off the noses of all voter/taxpayers too!

And yet, it is even more important to recognize that these shocking financial losses, as illustrated above, are but the tip of the iceberg when another important multiplier is factored in for the loss of the economic growth that would have been spawned if these huge financial losses had not occurred! These needless losses would have spawned and compounded more production, more jobs, better pay, new businesses and more efficient businesses, and a far more competitive U. S. economy in the worldwide marketplace.

In short, the economic losses due to the ordinary income tax treatment of saving are mind boggling!

IS IT ANY WONDER OUR NATION'S ECONOMIC STRENGTH IS BUCKLING UNDER THESE NEEDLESS, SELF-DEFEATING, SCANDALOUS LOSSES DUE TO THE ORDINARY INCOME TAX IMPACT ON SAVING!

Two additional points should be made.

First, all candidates for Federal public office, whether Presidential, House, or Senate, are properly focusing on "middle class" tax relief. **Thus, it is appropriate to point out that the staggering losses illustrated above have resulted in far higher ordinary income taxes being imposed over the past years on the middle class voter/taxpayer than otherwise needed!** We're all familiar with the variety of way taxes are continually ratcheted upward. A major cause of this is the unsound way we tax saving via the ordinary income tax. Let no one kid the "middle class"—they are, in fact, the money reservoir for taxes. "Low income" people can't provide the sums needed, and there aren't enough "high income" people, even if taxes are raised to confiscatory levels.

The only practical, proper solution to provide long-term tax relief is to permit savings to grow without tax until consumed (spent). By so doing, we all will gain handsomely—including the government.

Second, the ordinary income tax treatment of saving has been, and will continue to be if uncorrected, an unmitigated disaster. While these illustrations are based on actual mutual fund results over the past 65 years, it must be remembered that, as the old saying goes, the past is prologue. The next sixty-five years will probably have the same types of financial ups and downs in the economy as the past 65 years. **Thus, this most serious problem of the ordinary income tax treatment of saving must be corrected immediately; delay only makes it worse. This economic cancer can become "terminal".**

IRA Tax Treatment of Saving

Now, let us look at IRAs. The underlying facts of Table 2 are the same as for the ordinary income tax.

Table 2 portrays the financial results of **existing** saving **shifted** to an IRA. Note that IRAs create no "dead-weight losses". This is so because voter/taxpayers and the government enjoy the full rewards from unfettered-by-taxes free-market investment growth.

Table 3 is most important. It compares the IRA results of Table 2 with those under the Ordinary Income Tax of Table 1.

Ponder the magnificent financial gains, rather than losses, that would have been developed for our nation if **fully deductible IRAs** had been available over these past 65 years! To illustrate this, multiply the gains shown on Table 3 **by $10 million** (as we did with Table 1), and this picture emerges:

Nation's **IRA GAINS** Over the Ordinary Income Tax Per **$1 Billion** of Saving

	Year Investment Made and Duration		
	1981	1961	1926
Tax Bracket	10 Years	30 Years	65 Years
15%	$247.5 Million	$3 Billion	$431.4 Billion
31%	$591.9 Million	$6.6 Billion	$842.2 Billion
50%	$1.2 Billion	$12.3 Billion	$1,417.5 Billion

THESE IRA GAINS OVER THE ORDINARY INCOME TAX ARE MIND BOGGLING—AND REAL. PARTICULARLY WHEN ONE CONSIDERS THE BILLIONS AND BILLIONS OF DOLLARS THAT HAVE BEEN SAVED OVER THE PAST YEARS.

A more detailed review of Table 3 will establish these additional important points—

- Taxpayers lose with IRAs for at least five years. This occurs solely because of the 10% IRA penalty tax. This tax is self-defeating and discriminates against young, "low bracket" taxpayers. It needlessly discourages people from using IRAs in the first place.

- The government's claim that they lose money with IRAs is pure hogwash! Our government and our nation have ever-increasing gains from IRAs.

- The government has a revenue loss from an IRA tax deferral (see Table 2). This alleged "loss" is used by the government in establishing its "tax policy" for IRAs. It is clear from Table 3, however, that such a "loss" really creates robust governmental gains, because it creates increased free-market investments that are unfettered by taxes until withdrawn and taxed. Rather than being treated as an "expense", this alleged "loss" creates what is, in fact, an excellent tax receivable, i.e., an asset.

  And, contrary to governmental claims, higher tax bracket taxpayers don't have a "tax loophole" with IRAs—they actually create larger governmental gains!

Summary

In closing, it is appropriate to comment as follows—

All Committee members and all voter/taxpayers should reject any cry of alarm that IRAs increase the government's already sky-high debt. First time home buyers also raise their debt to what seems like sky-high levels without undue alarm, because their debt is collateralized by their home, and their earnings can support the payment. In short, there's an asset to offset the liability.

As illustrated in these Tables, every nickel of government debt arising from IRA tax deferrals is fully collateralized by voter/taxpayers' IRA assets. And, these IRA assets are invested in free-market enterprise that, in aggregate and over time, will produce total returns that exceed the cost of money to our government (e.g., T-bill rates). Any candidate for governmental office that claims that free enterprise investment growth can't match or exceed the government's cost-of-money is unworthy of anyone's vote.

While the appended illustrations reflect different tax brackets, it should be recognized that *the "tax deferral" of saving is bottomed upon sound common sense and sound economic sense, regardless of tax brackets now or in the future.* It's a win, win, win situation for our government, our voter/taxpayers, and our nation. Thus, regardless of the configuration of tax bills now being debated, IRA-type plans should be *greatly* expanded and improved.

And, Committee members and voter/taxpayers should not be swayed by the "bogeyman" of breaking the so-called Budget Summit Agreement. The governmental methods used to measure alleged losses from IRAs are not prescribed by law, nor by regulation. The methods being used were merely adopted by staff some years ago and have been, in essence, foisted on legislators, the Administration and thus, the public. It has been stated, with a degree of authority, that the existing methods remain unchallenged and in place because the government "wants the money". Never should sound legislation be held hostage to such a shortsighted, outlandish position—particularly when realistic facts are so compelling for change.

THE BOTTOM LINE IS THAT IRA SAVING SHOULD BE UNLIMITED, FULLY DEDUCTIBLE, WITHOUT PENALTY TAXES AND WITHOUT FORCED DISTRIBUTIONS.

Two bills have been introduced in the Senate and/or the House that go a long way toward addressing the needs expressed herein. S. 2144, introduced by Senator Breaux of this Committee, calls for the establishment of IRA IIs that meet most, if not all, of the desirable plan design criteria enumerated above. This Bill has also been introduced in the House by Mr. Jenkins (GA-9) and Mr. Schulze (PA-5), both being senior members of the House Ways & Means Committee (H. R. 3363). H. R. 1413, co-sponsored by Messrs. Schulze and Jenkins, calls for Congressional Hearings on Tax Expenditure Budget methodologies.

There is no rational reason why such a simple, sound, bold IRA expansion and improvement should not be debated, endorsed by every candidate for Federal office, and enacted promptly. In reality, there are no so-called "costs" to such IRAs; only major "gains" that must not be forsaken. Greatly expanded and improved IRAs are the finest, most productive step Congress can take on behalf of its constituents, our nation, and its tax revenue base.

Taxpayer, Government and Nation's Values Under Ordinary Income Tax Treatment

$100 of After-Tax Saving is Invested on January 1 of Year Shown
Investment Made in an Actual Mutual Fund (1)

ITEMS	Tax Bracket (3)	After-Tax Investment	Values on 12/31/90 from Investment Made on January 1, 19— and Maintained for — Years Duration							
			1990 1 yr.	1988 3 yrs.	1986 5 yrs.	1981 10 yrs.	1976 15 yrs.	1961 30 yrs.	1946 45 yrs.	1926 65 yrs.
Section A **Untaxed Mutual Fund** Value on 12/31/90 **(Full Value)**	ALL	$100.00	$99.04	$143.95	$172.70	$305.09	$679.80	$1,806.09	$9,176.31	$88,837.38
Section B	15%	$100.00	$97.50	$136.94	$159.78	$262.26	$550.71	$1,279.21	$5,359.14	$43,885.15
Taxpayer	28%	$100.00	$96.16	$130.99	$149.20	$229.18	$453.69	$937.14	$3,308.40	$23,358.67
After-Tax Value on 12/31/90	31%	$100.00	$95.85	$129.63	$146.83	$222.04	$433.07	$870.52	$2,952.22	$20,130.78
Under Ordinary Income Tax Treatment	50%	$100.00	$93.89	$121.16	$132.52	$180.78	$316.32	$534.02	$1,393.01	$7,551.17
Section C	15%	$100.00	$1.54	$6.94	$11.97	$35.89	$104.56	$363.39	$1,847.93	$15,750.80
Government's Tax Collection Value	28%	$100.00	$2.88	$12.83	$21.74	$63.33	$182.14	$589.26	$2,638.63	$19,733.13
on 12/31/90	31%	$100.00	$3.19	$14.17	$23.92	$69.21	$198.50	$631.95	$2,749.77	$19,961.91
Under Ordinary Income Tax Treatment (2)	50%	$100.00	$5.15	$22.54	$37.06	$102.86	$290.09	$838.08	$3,060.58	$18,501.54
Section D	15%	$100.00	$99.04	$143.88	$171.75	$298.15	$655.27	$1,642.60	$7,207.07	$59,635.95
Nation's Values on 12/31/90	28%	$100.00	$99.04	$143.82	$170.94	$292.51	$635.83	$1,526.40	$5,947.03	$43,091.80
Under Ordinary Income Tax Treatment	31%	$100.00	$99.04	$143.80	$170.75	$291.25	$631.57	$1,502.47	$5,701.99	$40,092.69
(B + C)	50%	$100.00	$99.04	$143.70	$169.58	$283.64	$606.41	$1,372.10	$4,453.59	$26,052.71
Section E	15%	$100.00	$0.00	($0.07)	($0.95)	($6.94)	($24.53)	($163.49)	($1,969.24)	($29,201.43)
Losses In Nation's Values			0%	0%	(1%)	(2%)	(4%)	(9%)	(21%)	(33%)
Under Ordinary Income Tax Treatment	28%	$100.00	$0.00	($0.13)	($1.76)	($12.58)	($43.97)	($279.69)	($3,229.28)	($45,745.58)
(D - A)			0%	0%	(1%)	(4%)	(6%)	(15%)	(35%)	(51%)
Loss As % of Full Value (D ÷ A)	31%	$100.00	$0.00	($0.15)	($1.95)	($13.84)	($48.23)	($303.62)	($3,474.32)	($48,744.69)
*			0%	0%	(1%)	(5%)	(7%)	(17%)	(38%)	(55%)
THESE "DEAD WEIGHT LOSSES"	50%	$100.00	$0.00	($0.25)	($3.12)	($21.45)	($73.39)	($433.99)	($4,722.72)	($62,784.67)
ARE A TOTAL WASTE			0%	0%	(2%)	(7%)	(11%)	(24%)	(51%)	(71%)

* These ever-increasing "dead weight" losses arise from a single $100 investment that is subjected to ordinary income tax treatment. If you *multiply* these losses *by $10 million,* it helps to portray the magnitude of the *financial losses* to our nation as of 12/31/90 from *each $1 billion* of U. S. taxpayers' saving invested on January 1 of a year shown. And yet, *these shocking financial losses are but the tip of the iceberg* when an added multiplier is factored in for the loss of the economic growth that would have been spawned *if these huge losses had not occurred!*

IS IT ANY WONDER OUR NATION'S ECONOMIC STRENGTH IS BUCKLING UNDER THESE NEEDLESS, SELF-DEFEATING, SCANDALOUS LOSSES DUE TO THE ORDINARY INCOME TAX!

#92-01a

Savers & Investors League

TABLE 2

Taxpayer, Government and Nation's Values Under IRA Tax Treatment

Pre-Tax Saving is Invested on January 1 of Year Shown

Investment Made in an Actual Mutual Fund (1)

ITEMS	Tax Bracket (3)	In Year Shown: After-Tax Saving (Table 1)	+ IRA TAX DEFERRED	= IRA Investment #	Values on 12/31/90 from Investment Made on January 1, 19— and Maintained for — Years Duration: 1990 1 yr.	1988 3 yrs.	1986 5 yrs.	1981 10 yrs.	1976 15 yrs.	1961 30 yrs.	1946 45 yrs.	1926 65 yrs.
Section F	15%	$100.00	$17.65	$117.65	$116.69	$167.01	$199.93	$359.63	$776.29	$2,056.11	$10,839.48	$102,953.28
Untaxed Mutual Fund	28%	$100.00	$38.89	$138.89	$137.93	$194.76	$232.71	$425.28	$892.44	$2,357.07	$12,841.43	$119,944.65
Value on 12/31/90	31%	$100.00	$44.93	$144.93	$143.97	$202.65	$242.03	$443.94	$925.45	$2,442.62	$13,410.55	$124,774.97
(Full Value)	50%	$100.00	$100.00	$200.00	$199.04	$274.60	$327.02	$614.14	$1,226.58	$3,222.88	$18,600.91	$168,827.50
Section G	15%	$100.00	$17.65	$117.65	$87.52	$125.26	$149.95	$269.72	$582.22	$1,542.09	$8,129.61	$87,510.29
Taxpayer	28%	$100.00	$38.89	$138.89	$85.52	$120.75	$144.28	$263.67	$553.31	$1,461.38	$7,961.69	$86,360.15
After-Tax Value on 12/31/90	31%	$100.00	$44.93	$144.93	$84.94	$119.56	$142.80	$261.92	$546.02	$1,441.15	$7,912.23	$86,094.73
Under IRA Tax Treatment	50%	$100.00	$100.00	$200.00	$79.62	$109.84	$130.81	$245.66	$490.63	$1,289.15	$7,440.37	$84,413.75
Section H	15%	$100.00	$17.65	$117.65	$11.52	$21.42	$27.22	$53.18	$140.63	$404.57	$2,567.78	$15,262.93
Government's Tax Collection Value	28%	$100.00	$38.89	$138.89	$13.52	$29.21	$38.27	$80.68	$221.34	$654.48	$4,566.63	$33,187.70
on 12/31/90	31%	$100.00	$44.93	$144.93	$14.10	$31.33	$41.28	$88.52	$243.37	$722.81	$5,136.59	$38,221.82
Under IRA Tax Treatment ✱	50%	$100.00	$100.00	$200.00	$19.42	$49.56	$67.23	$160.39	$433.08	$1,313.48	$10,355.39	$83,393.40
Section I	15%	$100.00	$17.65	$117.65	$99.04	$146.68	$177.17	$322.90	$722.85	$1,946.66	$10,697.39	$102,773.22
Nation's Values on 12/31/90	28%	$100.00	$38.89	$138.89	$99.04	$149.96	$182.55	$344.35	$774.65	$2,115.86	$12,528.32	$119,547.85
Under IRA Tax Treatment	31%	$100.00	$44.93	$144.93	$99.04	$150.89	$184.08	$350.44	$789.39	$2,163.96	$13,048.82	$124,316.55
(G + H)	50%	$100.00	$100.00	$200.00	$99.04	$159.40	$198.04	$406.05	$923.71	$2,602.63	$17,795.76	$167,807.15

This amount also represents the pre-tax saving needed for the after-tax investment in Table 1.

✱ Section H, the Government's IRA Tax Collection Values on 12/31/90, have been reduced to reflect the 12/31/90 value of the uncollected tax in year one, i.e., the IRA Tax Deferral.

The 10% IRA Penalty Tax is applied at all durations, except at 65 years due to the age 59 1/2 limitation.

#92-02a

Taxpayer's, Government's and Nation's Gains or (Losses) From IRA Tax Treatment When $100 of After-Tax Saving is Shifted to a Deductible IRA

(Table 2 minus Table 1)

ITEM	Tax Bracket (3)	Gains or (Losses) on 12/31/90 from Investment Made on January 1, 19--- and Maintained for — Years Duration							
		1990 1 yr.	1988 3 yrs.	1986 5 yrs.	1981 10 yrs.	1976 15 yrs.	1961 30 yrs.	1946 45 yrs.	1926 65 yrs.
Section J									
Taxpayers' Gain or (Loss)	15%	($9.98)	($11.68)	($9.83)	$7.46	$31.51	$262.88	$2,770.47	$43,625.14
From the	28%	($10.64)	($10.24)	($4.92)	$34.49	$99.62	$524.24	$4,653.29	$63,001.48
IRA Tax Treatment	31%	($10.91)	($10.07)	($4.03)	$39.88	$112.95	$570.63	$4,960.01	$65,963.95
(G - B)	50%	($14.27)	($11.32)	($1.71)	$64.88	$174.31	$755.13	$6,047.36	$76,862.58
Section K									
Government's Gain or (Loss)	15%	$9.98	$14.48	$15.25	$17.29	$36.07	$41.18	$719.85	($487.87)
From the	28%	$10.64	$16.38	$16.53	$17.35	$39.20	$65.22	$1,928.00	$13,454.57
IRA Tax Treatment	31%	$10.91	$17.16	$17.36	$19.31	$44.87	$90.86	$2,386.82	$18,259.91
(H - C)	50%	$14.27	$27.02	$30.17	$57.53	$142.99	$475.40	$7,294.81	$64,891.86
Section L									
Nation's Gain or (Loss)	15%	$0.00	$2.80	$5.42	$24.75	$67.58	$304.06	$3,490.32	$43,137.27
From the	28%	$0.00	$6.14	$11.61	$51.84	$138.82	$589.46	$6,581.29	$76,456.05
IRA Tax Treatment	31%	$0.00	$7.09	$13.33	$59.19	$157.82	$661.49	$7,346.83	$84,223.86
(I - J) or (J + K)	50%	$0.00	$15.70	$28.46	$122.41	$317.30	$1,230.53	$13,342.17	$141,754.44

The above gains or (losses) are from a single IRA contribution. Multiply the above figures ***by $10 million for each $1 billion*** of U. S. taxpayers' saving. By so doing, the magnitude of the *financial* gains from IRAs *for the government, our voter/taxpayers, and our nation* become more apparent. And, these *financial* gains are but the *tip of the iceberg*, because they would have spawned *dynamic, compounding economic growth*. As the old and valid saying goes: the past is prologue.

OUR VOTER/TAXPAYERS, OUR GOVERNMENT AND OUR NATION ARE BEING GROSSLY AND IRREPARABLY HARMED BY THE ORDINARY INCOME TAX TREATMENT OF SAVING. IRAS MUST BE GREATLY EXPANDED AND IMPROVED IMMEDIATELY. THERE IS NO RATIONAL ALTERNATIVE.

#92-03a

NOTES FOR TABLES 1, 2, & 3

(1) The mutual fund values reflect the fund's actual investment performance and its reported annual distributions during the indicated periods from 1/1/26 to 12/31/90. All distributions are reinvested. Incurred ordinary income taxes are based on the taxable distributions each year and on the sale of the fund on 12/31/90. IRA taxation occurs upon the IRA termination and cash distribution.

(2) To properly compare ordinary tax collections over the years with taxpayer end-of-period values on 12/31/90, it is necessary and proper to measure the government's collections each year. These tax collections are then carried forward with interest to 12/31/90 at a rate deemed to be the cost of money to the government, i.e. actual T-Bill rates during each of the indicated years.

(3) 50% tax bracket illustrations have been included for illustrative purposes, because over most of the past 65 years, this tax rate has been in effect.

STATEMENT OF THE SHOSHONE AND NORTHERN ARAPAHO TRIBES OF THE WIND RIVER RESERVATION

Alfred Ward, Chairman of the Shoshone Business Council, and Burton Hutchinson, Chairman of the Northern Arapaho Business Council, respectfully submit the following testimony concerning the impacts of the proposed 1993 federal budget on our reservation, together with our requests for restoration and/or increase in appropriations to meet the needs of our lands and people.

INDIAN HEALTH SERVICE

1. Providing critical additional space for clinics. The Tribes are requesting $500,000: $250,000 for the Fort Washakie IHS Clinic and $250,000 for the Arapaho IHS Clinic funded through Medicare/Medicaid reimbursements for the temporary construction.

The two IHS clinics at the Wind River Reservation have severe space problems. They fall far below IHS minimum standards developed in response to criticism by the Joint Commission on Accreditation of Health Care Organizations.

At the Fort Washakie facility, all of the departments are severely cramped. Four physicians and one secretary currently share an office totalling 200 square feet. At the Arapaho clinic there is no office space allotted to doctors.

The space shortage makes recruitment and retention of physicians difficult and, in addition, creates problems of maintaining confidentiality of patient information. The cramped quarters have a direct consequence in high turn-over of physicians which adversely effects the quality of health care and fewer preventative medicine activities.

2. Solid Waste Program. The Tribes need $500,000 to establish a solid waste collection system, $150,000 of which needs to be recurring funding for operational expenditures.

Funds available to states under RCRA are not currently available to Tribes. Tribes face legal liability for failure to clean up and maintain waste facilities. With the closing of BIA dumps, a solid waste collection system must be implemented.

BUREAU OF INDIAN AFFAIRS

1. Energy and Minerals Office. Funding for mineral assessments and special projects has been zeroed out in the Interior budget. These funds should be restored. Mineral assessment funds are used to assist the Tribes in evaluating oil, gas and other mineral reserves on the Reservation. It is obvious that development of these reserves is of major benefit not only to the reservation economy but to the national economy and, particularly, national energy needs.

2. Agriculture Programs. The Tribes request a $1.5 million appropriation for funding a reservation agriculture program. Tribal farmers and ranchers are severely handicapped in obtaining funds for on-farm improvements. While most ranchers are relatively successful, sufficient funds are rarely available to them from private sources. This funding would also help replace the business grant program which has not been funded in the President's proposed budget.

3. Soil Inventory. The Tribes request a $780,000 appropriation for a soil inventory. For several years, the Tribes have tried to get a soil inventory completed for the reservation. Everyone agrees that such an inventory is necessary to plan for prudent and productive use of reservation lands. A properly

completed soil classification provides crucial baseline data for making important land-use decisions as well as obtaining financial resources to make these tribal lands economically productive.

4. Business Development Grant Funds. The OMB has directed that, effective February 10, 1992, unobligated Business Development Grant Funds are rescinded. Over the past several years, this program has made it possible for numerous individuals on the reservation to secure loans to develop small businesses. In 1991, six individuals received grants of $78,000 which in turn produced $250,000 in funds from other lenders to develop small businesses. The Tribes request restoration of funding.

5. Non-Reimbursability of Irrigation Funds. The Tribes request support to have the irrigation rehabilitation funds appropriated in FY 1990, FY 1991, and FY 1992 made non-reimbursable. The Wind River irrigation project is in serious need of repair and improvement. The condition of the system impairs the Tribes' ability to use water adjudicated to it and hurts Indian irrigators and many of the non-Indian irrigators are in no position to absorb the costs needed to upgrade the system.

The Tribes strongly urge that the proposed language of the senate in the 1992 appropriations bill be included in the 1993 appropriations bill. There is no request for additional funding during 1993.

6. Safety of Dams. The Tribes have recently received a P.L. 93-638 contract to conduct safety of dams work on Ray Lake and Washakie Reservoir. The Tribes pursued these grants in part because of their concern that the Bureau of Reclamation's priorities for correction of dam problems were at odds with the Tribes. The Bureau of Reclamation focus is on short-term, low cost corrective measures. The Tribes viewed this as short-sighted, wasteful, and not in the Tribes' best interests. Therefore, the Tribes oppose the transfer of safety of dams programs to the Bureau of Reclamation. The Tribes are independently exploring the opportunities for increasing the capacities of the reservoirs and if the BOR takes over the safety of dams programs, the Tribes are deeply concerned that their interests and goals will not be addressed.

7. Juvenile Detention Facility. There is a critical need on the Wind River Reservation for a juvenile detention facility. There is currently no such facility in the area and this has often resulted in detaining juveniles in adult facilities -- a dangerous and disapproved measure. The Tribes need an appropriation for a juvenile detention facility which would provide a 72-hour holding facility. An appropriation of $1.6 million will be required, $200,000 of which should be designated as recurring funds for staffing, supplies and training. This facility, combined with the existing community programs for youth will become an important component of the law and order and the youth corrections program of the Tribes. Continued failure to establish such a program will mean that reservation youth are at risk for serious harm.

8. BIA Reorganization.

a. Establishment of Arapaho Subagency. The BIA agency offices are at Fort Washakie, the government center of the Shoshone Tribe. The BIA and the Arapaho Tribe have long advocated a subagency at the Arapaho's government center at Ethete, 30 miles from Fort Washakie. The subagency would provide for: (1) a law and order dispatcher; (2) establishment of an adult holding facility; (3) two to three social workers, needed to help Tribal members in such areas as children's protective services and general assistance applications; (4) a realty section staffed by two people (There are many questions that arise daily regarding the status of lands which

require accessing computer data.); and (5) a BIA officer to service Individual Indian Money Accounts.

Establishing a subagency at Ethete would require posting an assistant superintendent to supervise the operations of that office. The cost of this facility is $257,058 for operations and $212,000 for construction totalling $469,058 for FY 1993. The Arapaho Tribe urgently requests this appropriation.

b. Improvement of BIA Staffing for Land Operations. The Wind River agency is severely handicapped by under staffing in management of land operations. For example, there is no land surveyor. There is only one range specialist for 1-1.2 million acres. Other federal agencies, such as the Forest Service and Bureau of Land Management, have a range specialist for every 250,000 acres. Reservation lands present far more complex management problems because of multiple divided ownership.

Additional staff is urgently needed and the following have been requested by the agency and supported by the Tribes: (1) one land surveyor; (2) one agricultural engineer; (3) one range conservationist; (4) two range technicians; (5) two soils conservation technicians; and (6) a clerk-typist. The cost of that staffing, including initial start-up costs is $249,380. The Tribes request this sum be appropriated.

C. Additional technical staff for Fort Washakie agency. The BIA has advised the Tribes that it urgently needs the following additional technical staff: (1) an appraiser; (2) an archeologist; (3) a wildlife biologist. The cost of supplying this staffing, including vehicles and supplies, is $297,606. An additional appropriation in that amount is requested.

D. Agency Solicitor. The serious problems created by conflicts of interest within Interior have made the need for a solicitor at the agency level at Wind River critical. The Tribes fully support the recommendation of the BIA reorganization plan that such a solicitor be posted to the Fort Washakie Reservation. The cost of that function will be $121,905.

U.S. FISH & WILDLIFE SERVICE

1. Funding Clean Air Research. In 1990, Congress authorized $500,000 to the U.S. Fish and Wildlife Service to begin acid rain studies. The Wind River Mountains are extremely sensitive to incoming acid deposition. The $500,000 authorized by Congress contemplates a four-year program which requires $100,000 to begin in 1993. The Tribes request a $100,000 appropriation for this purpose.

2. Increased Funding for the Lander Office. The Lander Fish and Wildlife Management Office has been inadequately funded for over 10 years. The State of Wyoming and many wildlife organizations support increased funding for the office. The Lander Office base funding for FY 1992 is $198,000. An additional $300,000 is needed to meet important tribal fish and wildlife management needs. The appropriation would allow for monitoring fish plants in back country lakes and lowland reservoirs, population estimates and habitat evaluation of native species of fish, surveying and inventorying game such as antelope and big horn sheep and conducting wetland inventory and enhancement studies. The Tribes request an additional appropriation of $320,000 for the Lander Field Office to allow this to be accomplished.

STATEMENT OF THE SOCIETY FOR HUMAN RESOURCE MANAGEMENT

Mr. Chairman and Members of the House Ways and Means Committee: Thank you for the opportunity to comment and discuss with you Section 127 of the Internal Revenue Code, the tax exclusion for employer-provided educational assistance. Today, I am here to testily on behalf of the Society for Human Resource Management, SHRM, which represents the interests of 80,000 members from around the world including individuals from more than 400 professional and 200 student chapters. Formerly the American Society for Personnel Administration, SHRM provides its membership with ongoing government and media representation, education and information services, conferences and seminars, and publications that equip human resource professionals to become leaders and decision makers within their organizations. SHRM strongly urges the Congress to permanently extend Section 127 of the Internal Revenue Code.

SHRM was extremely disappointed that the President did not include the permanent extension of Section 127 in his tax package. We must support long term economic policies which promote investment in the human resources of this country, not only our technological resources. In the President's State of the Union Address he asserted that the only true test to a policy is, "Is it sound, and does it work?" This program is sound, and it already works.

My professional experience with Section 127 grows out of my nine years as Director of Training and Organization Development for Orion Capital Companies, a medium-sized property-casualty insurance company based in Farmington, Connecticut. In that role, I have personally administered the program throughout its turbulent history. Since we are a medium-sized employer (1,420 employees over 25 locations) who is not able to provide internal training programs to meet all of our employee development needs, Orion Capital Companies relies on local colleges and universities in our various locations as a key employee development resource.

We have an extensive "education reimbursement" program that ultimately pays 100% of the cost of tuition and books for successfully completed courses. Over the last two years fully one-third of our employees have taken one or more courses. Some are pursuing undergraduate degrees and a few are seeking graduate-level designations. Although a few attend "nationally-known" universities, most are attending local universities and community based colleges.

SHRM recognizes that the Congress is confronted with a looming deficit and the critical need to carefully invest and spend federal money. Therefore, we urge you to examine both the short and long term benefits of Section 127, which far outweigh the costs. I would like to take a few moments to point out these benefits and to provide specific, real world examples of the program's impact on the lives of employees at my own company.

First, in the long term, Section 127 actually generates revenue. Ultimately many educational assistance recipients "repay" the government through increased tax liabilities, since education most often leads to higher earnings. In 1987, the median income of employees with one to three years of college was 23 percent higher, and with four or more years of college was nearly 70 percent higher, than the median income of employees with only four years of high school. Without Section 127 benefits many employees would no longer have the financial means or incentive to pursue a post-secondary education, and much of the revenue that has been forecast from repealing Section 127 and making tuition reimbursement programs taxable would never be realized.

Second, the availability of Section 127 as a tax benefit decreases the likelihood of unemployment. There is an inverse correlation between unemployment rates and educational attainment. According to statistics from the Department of labor, the 1988 total unemployment rate among civilians with four or more years of college was 1.7 percent. Among those with one to three years of college, the unemployment rate rose to 3.7 percent and for those with only a high school diploma the rate jumped to 5.5 percent. Among the black population, the difference in unemployment rates by education level is even greater; the unemployment rate for those with four or more years of college is almost 8 percent lower than for those with only a high school diploma.

Third, Section 127 offers many employees the only affordable opportunity to improve their skills and pursue an education. The growing costs of education and reductions in student aid packages, combined with the current economic situation, have severely limited the options of the low and middle class populations in the post-secondary spectrum. Within my own company, I see many employees pursue a post-secondary degree who would clearly be unable to afford the tuition on their own.

The removal of the educational assistance tax exclusion would, in my opinion, seriously impact the willingness of employees to seek out college/university courses. Removal of the exclusion results in a net increase to the employee of 15 to 31% of the cost of the course(s), depending on the tax bracket of the employee. State taxes, where applicable, would further erode the affordability of these courses for our employees. At Orion Capital Companies, our education reimbursement program is viewed as an important employee benefit and the removal of the tax exclusion would serve to diminish the perception of that benefit at a time when other employee benefits are under considerable pressure and challenge. In the employees' mind, it's "one more slap at the working person."

In one case, a female employee, who was a divorced mother raising two teenagers, was serving as a secretary in our human resources area. She already had her bachelor's degree when she joined us as a secretary in the personnel department. She earned two Masters degrees under our education assistance program, one in personnel and another in counseling. She was promoted from secretary to lead recruiter ("Employment Specialist") and later to the number two position in our largest regional human resource location ("Regional Human Resources Supervisor"). Without the tax exemption, she is certain she would not have been able to prepare herself for these new positions.

In another case, a computer programmer in our company (a white male in his twenties with a wife and young child) is seeking his bachelor's degree in a special American Studies program for working adults at a nationally known four year college in the Hartford area. This employee's goal is a professional/supervisory position in a data processing unit and later in general management. The cost of this program would normally be well outside this employee's ability to pay. Even the tax impact would be enough to cause him to curtail the program.

A last example, is of a young black male who is a junior professional in our accounting area. This employee has a two year associate degree and is pursuing a bachelor's level accounting degree with our assistance. He has a working wife and two youngsters, so there are not a lot of extra dollars available for professional education. Once again, adding a 15 or 28% "surcharge" to that professional education would be likely to dissuade him from pursuing his education further.

As illustrated above, the tax exemption enables many employees to continue their educations despite the rising costs of post-secondary education and significant cuts in education. From 1981 to 1991 the estimated cost of attending a public university increased nearly 30 percent, and of attending a private university by more than 50 percent, while the personal income per capita increased by less than 20 percent (in 1990 constant dollars). Additionally, while college costs outpace inflation, middle class access to student aid programs has been severely limited as eligibility for grant programs has shifted to low-income students. lacking access to other funding for post-secondary education, Section 127 enables many workers to finance a post-secondary education.

If Section 127 is not permanently extended before it expires on June 30, 1992, millions of low and middle income Americans will be left without the only truly affordable means they have to pursue an education. Employer-provided educational assistance provides opportunities to precisely the Americans who need to upgrade their skills and vocational opportunities the most. According to surveys by SHRM and Coopers & Lybrand, 71 percent of employees using Section 127 earn less than $30,000 annually, and nearly 36 percent of people using Section 127 benefits earn less than $20,000 annually. Employer-provided educational assistance offers opportunities for workers to pursue the American dream who might otherwise believe it has become myth.

Finally, Section 127 is a long term investment in our economy. A century ago, a high school education was more than adequate for factory workers and a college degree was limited to a select few. Between now and the year 2000, for the first time in history, the majority of all new jobs will require post-secondary education. Many professions will require nearly a decade of study following high school, and even the least skilled jobs will require a command of reading, computing, and thinking that was once required only for professionals.

Technological changes and a more competitive international economy have increased the need for these high skill jobs. However, the United States is already experiencing labor shortages because of the shrinking labor pool and the crisis within the educational system. As global markets become more integrated, our country must be forward looking and seek out ways to provide tools to the private sector to train and develop our workers to meet the demands of intense international competition. Today, instead of meeting these demands, many of our country's future workers graduate from high school functionally illiterate. last year, the Secretary of labor's Commission on Achieving Necessary Skills reported that more than half of

American young people leave school without the skills needed for meaningful and productive employment. And, in a 1990 SHRM/Commerce Clearing House survey, 92 percent of the firms surveyed reported having employees without basic skills working for the firm. The last decade has witnessed a decline in American productivity, a decrease in real wages and an increasing number of Americans living in poverty. By offering our future and current work force an opportunity to gain the education and skills to be competitive, employer-provided educational assistance is a necessary long-term investment in America's economy.

Constantly allowing the provision to expire and retroactively reinstating it at a later date prevents thousands of additional employees from taking advantage of the benefit. In September 1990, at the beginning of a new semester, many SHRM members personally witnessed the negative effect of this lapse when Section 127 was allowed to expire. In addition, the difficulty of administering Section 127 due to its changing status, discourages employers from continuing the program.

In closing, I urge the Congress to seriously consider the implications of allowing Section 127 to permanently expire. The permanent cancellation of Section 127 would have costs that employers, employees and the government cannot afford to pay. Employers would pay by losing a vital tool to remain competitive within their industries. Employees would pay by losing an affordable opportunity to seek an education and increase their earnings. In the long term, the government would pay with a less competitive work force, lower productivity, and higher unemployment.

SHRM recognizes the fact that the Congress is involved with many other complex and important issues that sometimes overshadow Section 127. However, for millions of employees and the long term economic future of this country, the permanent extension of this important tax provision is critical. SHRM believes that Congress can not afford to overlook this vital educational tool, and urges Congress to adopt a permanent extension of the program.

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